80-1952

No. 80-

Office-Supreme Court, U.S.
FILED
MAY 19 1981
ALEXANDER L. STEVAS, CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, as Commissioner of the New York State Department of Health,

Petitioners,

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

ROBERT ABRAMS
Attorney General of the State of New York
Attorney for Petitioners
Two World Trade Center
New York, New York 10047
(212) 488-3023

SHIRLEY ADELSON SIEGEL
Solicitor General

JUDITH A. GORDON
MARION R. BUCHBINDER
Assistant Attorneys General of Counsel

Questions Presented

1. Should the Court of Appeals have determined the due process rights of nursing home Medicaid patients who are transferred from one level of care to another by their private physician or nursing home or from a lower to a higher level of care on the advice of federally-mandated Utilization Review Committees when no named respondent or identified class member alleged that he had been, or imminently would be, subject to such a transfer?

2. Is the transfer of a patient from one level of care to another, by a private physican or other private party, affected by state action solely because the patient is Medicaid-funded and one result of the transfer is a change in the amount of benefits paid on his behalf?

3. Is a nursing home Medical patient deprived of a protected interest in liberty or property, not shared with privately financed patients, which entitles him to a due process hearing when he is transferred from one level of care to another by his private physician or nursing home?

4. Is a nursing home Medicaid patient deprived of a protected interest in liberty which entitles him to a due process hearing about his transfer to a higher level of care on the advice of a Utilization Review Committee?

Parties in the Court Below

Robert Whalen, M.D., was a party in the court below in his capacity as Commissioner of the New York State Department of Health and individually. Petitioner Axelrod succeeded Dr. Whalen as Commissioner of Health on January 2, 1979, but was not sued individually. Dr. Whalen is not named as a party to this petition because damages were not awarded, and the declaratory and injunctive relief that was granted is not enforceable against him individually. The names of all the other parties in the court below appear in the caption of this petition.

TABLE OF CONTENTS

	PAGE
Questions Presented	i
Parties in the Court Below	ii
Opinions Below	1
Jurisdiction	2
Statement of the Case	2
Reasons for Granting the Writ	10
A. There was no case or controversy on any of the transfer issues decided below	11
B. The decision of a private physician or other private party to change the level of care of a Medicaid patient in a nursing home or to discharge the patient does not involve state action	12
C. A Medicaid patient in a nursing home is not deprived of a constitutionally protected interest in liberty or property when his private physician or nursing home transfers him from one level of care to another or when a Utilization Review Committee recommends his transfer to a higher level of care	16
Conclusion	20
APPENDIX A—Order of the United States Court of Appeals for the Second Circuit Denying Rehearing	1a

APPENDIX B—Opinion of the United States Court of Appeals for the Second Circuit 3a

APPENDIX C—Partial Final Judgment of the United States District Court for the Southern District of New York 19a

APPENDIX D—Endorsement of the United States District Court for the Southern District of New York 22a

TABLE OF AUTHORITIES

Cases

PAGE

Adickes S. H. Kress & Co., 398 U.S. 144 (1970) 14

Board of Regents v. *Roth*, 408 U.S. 564 (1972) 19

Burdeau v. *McDowell*, 256 U.S. 465 (1921) 10, 13

Burton v. *Wilmington Parking Authority*, 365 U.S. 715 (1961) 14, 15

Coolidge v. *New Hampshire*, 403 U.S. 443 (1971) 10, 13

Flagg Brothers, Inc. v. *Brooks*, 436 U.S. 149 (1978) ..14, 15

Gladstone Realtors v. *Village of Bellwood*, 441 U.S. 91 (1979) 11

Golden v. *Zwickler*, 394 U.S. 103 (1969) 11

Goldfarb v. *Virginia State Bar*, 421 U.S. 773 (1975) .. 14

Jackson v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974) 8, 10, 14, 15, 16

Marsh v. *Alabama*, 326 U.S. 501 (1946) 14

Moose Lodge No. 107 v. *Irvis*, 407 U.S. 163 (1972) .. 14

Nixon v. *Condon*, 286 U.S. 73 (1932) 14

O'Bannon v. *Town Court Nursing Center*, 447 U.S. 773 (1980) 9, 10, 14, 17, 18, 19

O'Shea v. *Littleton*, 414 U.S. 488 (1974) 11

Parham v. *J.R.*, 442 U.S. 584 (1979) 16

Pennhurst State School v. *Halderman*, — U.S., —, 49 U.S.L.W. 4363 (April 20, 1981) 17

Simon v. *Eastern Kentucky Welfare Rights Organization*, 426 U.S. 26 (1976) 12

Vitek v. *Jones*, 445 U.S. 480 (1980) 9

Warth v. *Seldon*, 422 U.S. 490 (1975) 12

Federal Statutes

	PAGE
28 U.S.C. § 1254	2
§ 1331	4
§ 1343	4
42 U.S.C. § 1381 *et seq.*	3
§ 1382c	3
§ 1395x	3
§ 1396 *et seq.*	4
§ 1396a	3, 5
§ 1396b	3

State Statutes

N.Y. Public Health Law Art. 28	2, 14
§ 2801-d	15
N.Y. Social Services Law § 2	3
§ 157	3
§ 158	3
§ 159	3
§ 209	3
§ 363-a	3

Federal Regulations

42 C.F.R. § 405.1121	14
§ 431.201	3

PAGE

§ 431.210 3
§ 431.220 3
§ 440.40 3
§ 440.150 3
§ 455.333 14
§ 456.433 3
§ 456 *et seq.* 3
§ 456.260 14
§ 456.305 3
§ 456.306 3
§ 456.331 3
§ 456.332 3
§ 456.334 3
§ 456.337-456.437 3
§ 456.406 3
§ 456.433 3
Subpart k 3

STATE REGULATIONS

10 N.Y.C.R.R. § 85.14-85.17 3
§ 414.14 14
§ 416.9 3
§ 421.13 13
Subpart 86-2 2

18 N.Y.C.R.R. § 358.4 3
Parts 485-491 3

No. 80—

IN THE

Supreme Court of the United States

OCTOBER TERM, 1980

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, as Commissioner of the New York State Department of Health,

Petitioners,

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

Opinions Below

The order of the Court of Appeals denying petitioners' request for rehearing is not reported. It is reproduced in Appendix A to this petition at pp. 1a-2a.

The opinion of the Court of Appeals is reported at 629 F.2d 817. It is reproduced in Appendix B to this petition at pp. 3a-18a.

The endorsement and partial final judgment of the district court are not reported. They are reproduced respectively in Appendices C and D to this petition at pp. 19a-21a and p. 22a.†

Other opinions in this case, which do not involve the questions presented in this petition, are reported at 592 F.2d 65 and 456 F. Supp. 653.

Unreported decisions, which do not involve the questions presented in this petition, were filed in the district court on January 10, 1978 and April 8, 1981.

Jurisdiction

This Court has jurisdiction over the questions presented under 28 U.S.C. § 1254(1).

The opinion of the Court of Appeals issued on August 25, 1980, and the order denying petitioners' request for rehearing issued on February 18, 1981.

Statement of the Case

The named respondents and intervenors-respondents are medical assistance ("Medicaid") recipients who are now, or have been, patients in private skilled nursing facilities ("SNFs") or private health-related facilities ("HRFs") in New York.* SNFs offer a higher level of medical care

---

† Appendices to this petition are cited hereafter as "App. —, p. —."

*Both SNFs and HRFs are certified and regulated by the New York State Department of Health which also sets the reimbursement rates for the services they provide to Medicaid eligible patients. *See* New York Public Health Law ("NYPHL") Art. 28; 10 New York Code, Rules and Regulations ("NYCRR") Subpart 86-2.

than HRFs, and SNF Medicaid reimbursement rates are generally higher.* Between 1975-1977, Utilization Review Committees ("URCs")** determined that respondents and intervenors-respondents no longer needed the level of care they were receiving and recommended transfers to facilities with lower levels of care, i.e., those who were patients in SNFs were to be transferred to HRFs, and those in HRFs, transferred to private proprietary homes for adults ("PPHAs").*** The URC determinations were affirmed by the Commissioner of the Department of Social Services after administrative fair hearings were con-

---

* *See* 42 CFR Subpart k, §§ 440.40 and 440.150. Medicaid reimbursements are paid directly to the nursing home "provider" by the New York State Department of Social Services, the "single state agency" administering the state's Medicaid program. *See* New York Social Services Law ("NYSSL") § 363-a.

** Congress established the utilization review system to ensure that Medicaid patients receive appropriate levels of care and to eliminate unnecessary costs. *See* 42 U.S.C. § 1396a(a)(26); 42 CFR § 456 *et seq.* Utilization review requires SNF and HRF nursing homes to establish URCs of two or more physicians and other appropriate personnel not directly responsible for the care of the patients being reviewed. The URCs periodically review Medicaid-funded patients to determine if they need the level of care they are receiving or if a different level of care is more suitable. *See* 42 U.S.C. §§ 1395x(k), 1396a(a)(28) and 1396b(i)(4); 42 CFR §§ 456.305, 456.306, 456.331, 456.332, 456.334, 456.406 and 456.433; 10 NYCRR §§ 85.14-85.17, 416.9 and 421.13. Notice and opportunity for an administrative fair hearing are required if a URC determines that a patient should be transferred to a lower level of care. 42 U.S.C. § 1396a(a)(3); 42 CFR §§ 431.201, 431.210, 431.220 and 456.337-456.437; 18 NYCRR § 358.4(a).

*** PPHAs are privately owned and operated non-medical facilities regulated by the Department of Social Services. See NYSSL § 2(26); 18 NYCRR Parts 485-491. Publicly assisted PPHA residents receive federal and state Supplemental Security Income ("SSI") or Home Relief. *See* 42 U.S.C. § 1381 *et seq.;* NYSSL §§ 157, 158 and 209. Both SSI and Home Relief are paid directly to the recipient. 42 U.S.C. § 1382c; NYSSL §§ 131 (10) and 159. The recipient then pays the PPHA the amount required by his individual contract. Although PPHA residents may be Medicaid eligible, no PPHA receives Medicaid funds because it is not a provider of medical services.

ducted.* No respondent, intervenor-respondent or identified class member was transferred to, or recommended for transfer to, a higher level of care in the course of the proceedings, and no transfer to a lower level of care, other than the URC determinations noted above, was made, or recommended for, any such individual.

Respondents Yaretsky and Cuevas commenced the action on July 28, 1976, against the then Acting Commissioner of the Department Social Services and J. Raymond Diehl, Acting Deputy Commissioner of that agency.** Their complaint alleged violations of the Fourteenth Amendment, Title XIX of the Social Security Act (42 U.S.C. § 1396 *et seq.*) and its implementing regulations. More specifically, respondents challenged the composition of URCs, the URCs' methods in evaluating their needs, the adequacy of the Social Services Commissioner's review of URC determinations, the merits of the URC and Commissioner determinations approving lower levels of care for them and the alleged failure of Social Services personnel to advise them of their rights to, and at, fair hearings to review their URC determinations. Declaratory and injunctive relief was sought. Federal jurisdiction was alleged under 28

---

* Neither of the individual respondents was in fact transferred pursuant to the URC determinations, and the transfers of the intervenors-respondents were enjoined by the district court. According to information provided by the American Nursing Home in April, 1981, respondent Yaretsky remained in his SNF for approximately one and one-half years after the Commissioner's March, 1976, decision affirming the URC determination that he be transferred to an IIRF. He was later transferred to Bellevue Hospital, and it is believed that he died sometime before January 10, 1978. Respondent Cuevas is still a patient in the same SNF from which he was to be transferred in 1976. Intervenor-respondent Rossoff was transferred from an IIRF to a PPHA with her consent.

** Philip Toia, the original Social Services defendant, became Commissioner on May 10, 1976, and remained in that office until August 3, 1977, when he was succeeded by Carmen Shang. Mr. Shang was succeeded by Barbara Blum, the present Commissioner, on December 1, 1977.

U.S.C. §§ 1331, 1343(3) and 1343(4).*

Temporary restraining orders were granted in December, 1977, prohibiting the transfers of the intervenors-respondents. See discussion, p. 4, first footnote. In an unreported decision and order filed on January 10, 1978, the district court partially resolved the claims alleged in the complaints by preliminarily enjoining petitioners to provide adequate notice of URC determinations on transfers to lower levels of care, resulting in reduced Medicaid benefits, and to permit patients subject to such transfers access to their complete medical records at their nursing homes. The preliminary injunction was affirmed by the Court of Appeals on January 16, 1979. 592 F.2d 65.**

In their March 6, 1979 joint pretrial order, the parties agreed that since July, 1978, the petitioners had considered all URC determinations recommending transfers to higher levels of care to be advisory and without prejudice to the patient's right to remain at a lower level of care with his

---

* Respondents' amended complaint, dated April 7, 1977, and intervenors-respondents' complaint, filed in December, 1977, repeat the claims alleged in the original complaint. The amended complaint adds a claim that petitioners' failure to require each licensed nursing home to provide multiple levels of care violates 42 U.S.C. § 1396a(a)(19), a claim for damages and class action allegations. Robert A. Whalen, M.D., then Acting Commissioner of Health, was joined as a defendant (see *Parties in the Court Below, p. ii*), and J. Raymond Diehl was dropped.

** The parties entered into a partial consent judgment in May, 1979 (filed as a partial final judgment of the court by order of October 17, 1979), before the preliminary injunction was made permanent. Opinion below, App. B, p. 7a. The partial consent judgment embodied certain procedural safeguards for URC transfers to lower levels of care, including patient consent. *Ibid.* It reserved certain claims for future litigation, including the private physician and nursing home transfers to different levels of care and URC-recommended transfers to higher levels of care now in issue. *Ibid.* It also reserved the claims about the adequacy of URC evaluations and petitioner Blum's review of those evaluations as well as the alleged requirement that all licensed nursing homes provide multiple levels of care. See discussion, p. 4 and first footnote above. The claim for damages was neither settled nor reserved.

full Medicaid benefits in tact.* They also agreed that Medicaid patients recommended for transfer to another level of care by their private physician or nursing home could obtain URC review and the administrative fair hearing rights that attend such review.** This agreement, when read with the parties partial consent judgment, permits a Medicaid patient to veto a physician or nursing home transfer to a lower level of care in a different 'facility without prejudice to his right to remain at a higher level of care with full Medicaid benefits intact.***

---

* The joint pre-trial order states as follows at ¶ 56 of the stipulated facts:

> "Since approximately July, 1978, it is defendant's [petitioners'] policy that URC determinations which recommend a higher level of care are advisory opinions and not mandatory determinations. Medicaid payments will not be terminated if a patient refuses to comply with a URC recommendation that a higher level of care is needed."

** The joint pre-trial order states as follows at ¶ 60 of the stipulated facts:

> "It is defendant's [petitioners,] policy that patients recommended for transfer to another level of care by the facility, its agents, or the patients' attending physician, do not have a right to prior notice and hearing to review such determination, although the patient may request that the decision be reviewed by the URC and upon such review [is entitled to the same procedural rights, i.e. notice and opportunity for an administrative fair hearing, that attend URC recommendations for lower levels of care.] Defendants [petitioners] are presently reviewing this policy and may stop such reviews."

Petitioners in fact continued the policy and have not advised the court or the respondents and intervernors-respondents to the contrary at any time during the proceedings.

*** The partial consent judgment states as follows at ¶ II(F)(2):

> "No finding, determination or other decision . . . by a Utilization Review committee . . ., can be approved or implemented:
>
> • • •

(footnote continued on following page)

The transfers of Medicaid patients to different levels of care by their physician or nursing home, or to higher levels of care on the advice of URCs, in issue on this petition, were first raised in the partial consent judgment and reserved for future litigation. App. B, p. 7a and discussion p. 5, second footnote.

Although, as just established, physician and nursing home transfers to lower levels of care and URC-recommended transfers to higher levels of care were voluntary under the terms of the partial consent judgment and the joint pre-trial order, the district court endorsement awards summary judgment to respondents and intervenors-respondents, finding that all the transfers in issue require due process hearings because state action is involved. App. D, p. 22a.* A (second) partial final judgment conforming

---

(*footnote continued from preceding page*)

"If it is medically contraindicated:

* * *

"an adverse UR finding resulting in an out-of-facility transfer shall be deemed medically contraindicated unless the patient has voluntarily (i.e. knowingly, willingly and with knowledge of alternatives) consented to the transfer; provided that transfer within a geographic and operational entity providing both skilled nursing and health related care and services is not an out-of-facility transfer."

Since a Medicaid patient recommended for a different level of care by his physician or nursing home has the same procedural rights as a Medicaid patient recommended for a lower level of care by a URC (pre-trial order ¶ 60 set forth at p. 6, first footnote) the physician- or nursing home-referred patient obtains the right trial consent judgment quoted just abve.

* Summary judgment was also awarded on an aspect of the reserved claim about the adequacy of petitioner Blum's review of URC determinations. The petitioner, or her designee, was required to read verbatim transcripts of administrative fair hearings before affirming URC determinations adverse to patients. App. C. p. 20; App. D, p. 22a.

with the endorsement was issued on December 13, 1979. App. C, pp. 19a-21a. It decrees, *inter alia*, that petitioners' failure to provide prior written notice and prior opportunity to be heard at evidentiary hearings with respect to the transfers in issue deprived the Medicaid patient class of due process of law, and it enjoins petitioners to provide the appropriate notice and hearings. App. C, p. 20a-21a.*

The Court of Appeals modified and then affirmed the district court injunction on the transfer issues, holding that Medicaid patients in nursing homes are constitutionally entitled to due process hearings prior to URC-recommended transfers to higher levels of care and prior to physician and nursing home transfers from one level of care to another. App. B, p. 7a.** According to the opinion, the transfers are within the Fourteenth Amendment because they involve state action affecting protected interests in liberty or property. *Id.*, at pp. 7a-8a. The medical choices of physicians, nursing homes and URCs are viewed as state-delegated decisions to increase or reduce Medicaid benefits and thus "fairly treated as . . . [acts] of the State itself." *Jackson v.*

---

* The class defined in the same partial final judgment is "all Medicaid recipients in the State of New York who are residents of skilled nursing facilities or health-related facilities in the State." App. C, pp. 19a- 20a.

** The Court of Appeals modified the injunction on the transfer issues to permit it to be vacated if HEW (now HHS) determined that the procedures there mandated made New York wholly or partially ineligible for federal Medicaid reimbursement. *Id.*, at p. 15a. It also reversed and vacated the district court injunction requiring petitioner Blum to read the verbatim transcripts of fair hearings before finding adversely to patients recommended for transfer. *Id.*, at pp. 11a-18a. The petition for certiorari of respondents and intervenors-respondents on the transcript issue was denied by this Court on Februay 23, 1981. — U.S. —, 67 L. Ed. 355.

Metropolitan Edison Co., 419 U.S. 345, 351 (1974). *Id.*, at p. 7a. A physician or nursing home transfer of a patient to a lower level of care, i.e. from an SNF to an HRF, or a patient's discharge, is held to deprive him of a constitutionally protected property right because of the consequential reduction, or elimination, of the Medicaid benefits paid on his behalf. *Id.*, at 9a. A patient's transfer to higher level of care, whether by his physician or nursing home, or URC-recommended, is identified with the transfer of a state prisoner to a mental institution considered in *Vitek* v. *Jones*, 445 U.S. 480, 488-91 (1980) (*Id.*, at p. 10a) and held to deprive the nursing home patient of a constitutionally protected liberty interest because of the effects of transfer trauma. *Id.*, at pp. 9a-10a. This Court's decision in *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980), holding that the potential for transfer trauma is not a protected liberty interest, is distinguished on the two grounds. First, injury to the patients in this case is said to be more direct than in *O'Bannon* although patient transfers in both cases were occasioned by third parties, i.e. nursing homes or related personnel, and no difference in impact is noted (*Ibid.*). Second, the record in this case is said to include more information supporting the existence of transfer trauma than the *O'Bannon* record although the district court did not hold a hearing on this issue, and no affidavits on point were received. *Id.*, at p. 10a. The Court of Appeals did not consider the effect of petitioners' policies which permit patients recommended for higher levels of care by URCs and certain patients recommended for lower levels of care by their physicians or nursing homes to choose the level of care they prefer without prejudice to the continuance of full Medicaid benefits. See discussion, pp. 5-7. The Court also did not consider whether any named respondent, intervenor-respondent or identified class member had been, or imminently would be, subject to a URC-recommended transfer to a higher level of care

or a physician or nursing home transfer to a different level of care. Nor did the Court consider the fact that none of these possibilities was alleged in any of the complaints.

Reasons for Granting the Writ

The Court of Appeals opinion conflicts with prior decisions of this Court defining the limits of state action under the Fourteenth Amendment, including *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974), upon which it relies. In no case has the Court permitted the decisions of private parties, like the medical decisions here in issue, to be treated as state action merely because the state permits the decisions to be made, *Jackson* v. *Metropolitan Edison Co.*, 419 U.S., at 349, 350-51, or provides a conforming response, as in the increase or decrease of Medicaid benefits to accommodate the privately determined changes in medical treatment in issue. *See Coolidge* v. *New Hampshire*, 403 U.S. 443, 484-90 (1971); *Burdeau* v. *McDowell*, 256 U.S. 456 (1921). Transfer trauma, the basis for the Court of Appeals finding a protected liberty interest in Medicaid patient transfers to higher levels of care, was rejected as unworthy of constitutional protection last Term in *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980). The property right of constitutional dimension the Court of Appeals found present in transfers to lower levels of care again mistakes private action for state action and finds a claim of entitlement to constitutional protection where none is justified. *O'Bannon* v. *Town Court Nursing Center*, 447 U.S., at 785-88; id., at 795-802 (BLACKMUN, J. concurring). The Court of Appeals reached its conclusions although no named respondent, intervenor-respondent or identified class member alleged that he had been, or imminently would be, subject to any of the transfers it considered and in face of the fact that certain transfers to higher and lower levels of care were voluntary.

A. There was no case or controversy on any of the transfer issues decided below.

No plaintiff can meet the case or controversy requirement of Article III unless he demonstrates to the district court that he has suffered some actual or threatened injury as a result of the action challenged. *Gladstone Realtors* v. *Village of Bellwood,* 441 U.S. 91, 99 (1979); *O'Shea* v. *Littleton,* 414 U.S. 448, 493-94 (1974). Insofar as relevant to this petition, respondents and intervenors-respondents, by motion, challenged URC-recommended transfers of Medicaid patients to higher levels of nursing home care and physician and nursing home transfers of such patients from one level of care to another, including the patients' release to non-medical facilities and their discharge, on the ground that the failure to provide evidentiary administrative hearings violated the patients' rights to due process of law. Both the district court (App. D, p. 22a) and the Court of Appeals (App. B, pp. 7a, 9a) decided the issues in their favor. However, no respondent, intervenor-respondent or identified class member alleged that he had been subject to any of the challenged transfers.* None even attempted to show that he was threatened with a challenged transfer, let alone demonstrate that the threat was "real and immediate". See *O'Shea* v. *Littleton,* 414 U.S., at 496-97; *Golden* v. *Zwickler,* 394 U.S. 103, 109-110 (1969).**

---

* The allegations in the complaints of respondents and intervenors-respondents were limited to URC transfers to lower levels of care. See discussion, pp. 2-5. They were settled in a partial consent judgment after the Court of Appeals' first decision in this case. See discussion p. 5, second footnote. No Medicaid patients who were URC-recommended for higher levels of care or transferred to different levels of care by their physicians or nursing homes were added, or identified, during any of the proceedings below.

** Notably, no Medicaid patient in a nursing home could have been "threatened" by a URC-recommended transfer to a higher level of care or by a physician or nursing home transfer to a lower level of care in a different facility when the district court issued the endorsement (App. D, p. 22a) and partial final judgment (App. C, pp. 19a-21a) considered below. All URC-recommended

(footnote continued on following page)

The district court's certification of a class of "all Medicaid recipients in the State . . . who are residents of skilled nursing facilities or health-related facilities" (App. C, pp. 19a-20a) did not alter the obligation to satisfy the case or controversy requirement with respect to the specific transfer issues raised in this petition. The named class representatives were required to "'allege and show that they personally have been injured, not that injury has been suffered by other unidentified members of the class to which they belong.'" *Simon* v. *Eastern Kentucky Welfare Rights Organization,* 426 U.S. 26, 40 n. 20 (1976), quoting *Warth* v. *Seldon,* 422 U.S. 490, 502 (1975). Respondents and intervenors-respondents did not make the relevant showing.

The challenged URC-recommended transfers to higher levels of care and the physician and nursing home transfers to lower levels of care in different facilities did not satisfy the case or controversy requirement for the additional reasons that URC transfers had been voluntary since July, 1978, and physician and nursing home transfers, voluntary since May, 1979. See discussion, pp. 5-7, 11, second footnote. Thus, the presumed predicate for considering the due process claim against these transfers, an involuntary change in the level of care afforded a Medicaid patient affected through state action, was not present, and the relevant rulings below refer to a hypothetical case.

B. The decision of a private physician or other private party to change the level of care of a Medicaid patient in a nursing home or to discharge the patient does not involve state action.

In New York, a change in a nursing home patient's level of care is a medical decision between the patient and his

---

(footnote continued from preceding page)

transfers to higher levels of care have been voluntary since at least July, 1978 (see discussion, pp. 5-6), and all physician and nursing home transfers to lower levels of care in different facilities have been voluntary since May, 1979 (discussion, pp. 6-7).

physician or other private health care professional.* The decision is the same for all patients regardless of whether their bills are paid privately or by Medicaid. In contrast to the palpably erroneous finding below (App. B, p. 8a), a confidential medical judgment for privately financed patients does not become a delegated state decision for Medicaid patients because public assistance benefits are subsequently increased or decreased. Indeed, once the Court of Appeals acknowledged that the adjustments in Medicaid benefits upon which it relied were determined by, and responded to, prior private medical decisions about the levels of care eligible patients should receive (App. B, p. 8a), a ruling in petitioners' favor on the state action issue was required. As prior decisions of this Court establish, a state or public response to private action does not transform the private action into state action. *Coolidge* v. *New Hampshire*, 403 U.S. 443, 484-90 (1971); *Burdeau* v. *McDowell*, 256 U.S. 465 (1921).**

---

* According to the opinions of the Court of Appeals in this case, a URC is a "private party" when it recommmends transfers to lower or higher levels of care. 592 F2d 65, 67 n.3 (2d Cir. 1979) (higher to lower levels of care); opinion below, App. B, p. 8a (lower to higher levels of care). As noted, URC determinations on both types of transfers are advisory and subject to patient veto. See discussion, pp. 5-6.

** The opposing view of the Court of Appeals gives Medicaid patients potential Fourteenth Amendment claims against their private physicians or health care professionals which are not available to privately financed patients. The potential claims involve any change in treatment that results in an adjustment of benefits. Examples of Medicaid decisions encompassed by the Court's theory are a doctor's prescription of a different, and coincidently less expensive drug, for a chronicly ill patient; the transfer of a patient from a semi-private hospital room to the intensive care unit; and the discharge of a patient from a hospital or nursing home as recovered. In addition, the Court's theory leaves all medical decisions that do not result in increased or deceased cost, e.g. a patient transfer from between SNFs that are paid the same Medicaid rate, outside the Fourteenth Amendment when they may have the same effect, e.g. transfer trauma, as the decisions the Court found within its protection.

Jackson v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974), the only decision of this Court cited on the state action issue in the opinion below, is consistent with the principle just stated. *Jackson* also reaffirms the Court's consistent holdings that action by a private party is not considered state action unless it is compelled by the state acting as sovereign, *e.g. Flagg Brothers, Inc.* v. *Brooks*, 436 U.S. 149, 164-66 (1978); *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 791 (1975); *Moose Lodge No. 107* v. *Irvis*, 407 U.S. 163 (1972); *Adickes* v. *S.H. Kress & Co.*, 398 U.S. 144, 170 (1970); involves the exercise of a public function or the delegation of powers traditionally reserved to the state, *e.g. Flagg Brothers, Inc.* v. *Brooks*, 436 U.S., at 157-60; *Marsh* v. *Alabama*, 326 U.S. 501 (1946); *Nixon* v. *Condon*, 286 U.S. 73 (1932); or is performed by a private party with which the state is interdependent, *Burton* v. *Wilmington Parking Authority*, 365 U.S. 715 (1961). No such circumstances are presented by the transfers of nursing home Medicaid patients here in issue.

New York does not compel private physicians, nursing homes or URCs to transfer patients to different levels of care. There is no regulation in this regard for private physicians. Nursing homes are prohibited from transferring their patients for reasons not here relevant and are permitted to transfer them for medical reasons. NYPHL Art. 28; 42 CFR § 405.1121(k)(4); 10 NYCRR § 414.14(a). See *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773, 780 n. 9 (1980).* Federally-mandated URCs periodically review Medicaid nursing home patients, requiring physician certifications that the patients need the level of care provided. *See* 42 CFR §§ 456.260 and 455.333 and discussion, p. 3, second footnote.** As appears, state law

---

* As noted (pp. 6-7), New York permits a patient to veto a physician or nursing home transfer to a lower level of care in a different facility as a matter of policy.

** As noted (pp. 5-6), URC-recommended transfers to higher levels of care are advisory in New York and subject to patient veto, also as a matter of policy.

and policies simply allow the transfers in issue, an insufficient basis for treating the relevant medical decisions as state action. *Flagg Brothers, Inc.* v. *Brooks*, 436 U.S., at 164-66; *Jackson* v. *Metropolitan Edison Co.*, 419 U.S., 349, 350-51.

Nor do the challenged transfers involve the delegation of a public function to, or the exercise of state powers by, a private party. As established, a private physician or nursing home transfer of a Medicaid patient to another level of care or a URC recommendation for a higher level of care is a private decision based on the patient's medical needs. The state then responds to the decision by adjusting Medicaid benefits to conform with the treatment choice of the patient and his health care professional. It does not delegate the adjustment of Medicaid benefits to the health care professional any more than it delegates the adjustment of AFDC benefits to a landlord who evicts a mother and her dependent children, requiring them to seek shelter in a hotel at increased cost and consequentially increased benefits. Plainly, the medical decisions at issue herein cannot be considered delegations of sovereign authority when the warehousemen's power to execute liens was not so considered in *Flagg Brothers*, 436 U.S., at 157-63. In addition, the Medicaid patients here, like the bailors in *Flagg Brothers*, have common law and statutory causes of action against their physicians and nursing homes (e.g. NYPHL § 2801-d) in which they can resolve questions about the appropriateness of their care directly.

Finally, the challenged transfers cannot be considered state action under the "interdependency" or "symbiotic relationship" test of *Burton* v. *Willimgton Parking Authority, supra.* The restaurant that practiced racial discrimination there held to be affected with state action was a lessee of the state parking authority which had "so far insinuated itself into a position of interdepen-

dence with the restaurant that it was a joint participant in the enterprise." *Jackson* v. *Metropolitan Edison Co.*, 419 U.S., at 357-58. New York does not participate in the private medical decisions here in issue at all. It merely accommodates them.

C. A Medicaid patient in a nursing home is not deprived of a constiutionally protected interest in liberty or property when his private physician or nursing home transfers him from one level of care to another or when a Utilization Review Committee recommends his transfer to a higher level of care.

The Court of Appeals mistakenly reached two questions: whether a nursing home Medicaid patient has a constitutionally protected property right which is affected by a physician or nursing home transfer to a lower level of care in different facility (App. B, p. 9a); and whether the patient has a constitutionally protected liberty interest which is affected by a URC recommendation in favor of a higher level of care. *Id.*, at pp. 9a-10a. Both types of transfers were voluntary during the relevant proceedings before the district court and Court of Appeals.* As a result, they could not deprive a Medicaid patient of any interest, and there was no occasion to consider whether the particular interests involved were of a constitutional dimension. *Parham* v. *J. R.*, 442 U.S. 584, 622 (1979) (STEWART, J. concurring).

If the patient interests in all of the challenged transfers were properly reached, the Court of Appeals committed palpable error in finding that constitutionally protected interests in liberty and property were involved. App. B, pp.

---

* Physician and nursing home transfers to lower levels of care in different facilities have been voluntary since May, 1979, i.e. subject to patient veto and without prejudice to the continuance of Medicaid benefits conforming with the level of care the patient choses. See discussion, pp. 6-7. URC recommendations in favor of higher levels of care have been advisory since July, 1978, and equally without prejudice to the patient's remaining at his preferrel level of care. See discussion pp. 5-6.

8a-10a. "This Court has never found that the involuntarily committed [to state mental institutions] have a constitutional right to treatment, much less the voluntarily committed. See *Sanchez* v. *New Mexico*, 396 U.S. 276 (1970), dismissing for want of a substantial federal question, . . .; *O'Connor* v. *Donaldson*, 422 U.S. 563, 587-89 (1975) (BURGER, C. J. concurring)." *Pennhurst State School* v. *Halderman*, —— U.S. ——, 49 U.S.L.W. 4363, 4367 n. 13 (April 20, 1981). *A fortiori*, Medicaid patients who voluntarily enter private nursing homes and who are attended by their own physicians have no constitutionally protected interest in the level of care they receive. Their rights in this regard are thus the same as, and not higher than, the rights of privately financed patients. See *O'Bannon* v. *Town Court Nursing Center*, 447 U.S., at 787.

Analyzing the Medicaid patient's alleged liberty and property interests separately, as in the opinion below (App. B, pp. 8a-10a), does not produce a different result. The Court of Appeals found a protected liberty interest for physicians and nursing home transfers to higher levels of care and URC recommendations for such care. For this purpose, it relied on a speculative condition called "transfer trauma" (*Id.*, at pp. 9a-10), previously rejected as the basis for a liberty interest of constittuional dimension in *O'Bannon* v. *Town Court Nursing Center*, 447 U.S., at 784; id., at 802-804 (BLACKMUN, J. concurring). Although the Court of Appeals found that the impact of the transfers in this case was more direct than in *O'Bannon*, it did not state any basis for its conclusion (App. B, pp. 9a-10a), and none is discernible. See *O'Bannon* v. *Town Court Nursing Center*, 447 U.S., at 793 (BLACKMUN, J., concurring). The Court of Appeals alternative reliance on the allegedly "ample" record supporting the existing of transfer trauma in this case, and not available in *O'Bannon*, is also misplaced. This Court assumed transfer trauma existed for purposes of its *O'Bannon* decision. 447 U.S., at 784 p. 16. Thus, the Court of Appeals could not

rely on an allegedly better record supporting the same proposition to reach a different result. In fact, the record in this case is not more ample than the record in *O'Bannon*. There was no evidentary hearing before the district court on the question, and no affidavits on point were received. See 447 U.S., at 784 n. 16, similarly characterizing the *O'Bannon* record.

The Court of Appeals found a protected property interest in physician and nursing home transfers to lower levels of care, including the discharge of a patient, or his release to a non-medical adult home, or PPHA. App. B, p. 9a. For this purpose, it relied on the fact that the patient's " 'essentially financial' " " 'direct benefits' " are reduced or withdrawn to conform with the change in his treatment program. App. B, p. 9a, quoting *O'Bannon* v. *Town Court Nursing Home Center*, 447 U.S., at 786-87. The ruling disregards the fact that the determinative decision is the private, medical decision of the patient and his health care professional and misapplies the property right analysis presented in *O'Bannon*. In contrast to the situation in which the state denies public assistance directly, i.e. on the basis of its own investigation and finding of ineligibility or other disqualifying condition (see *O'Bannon* v. *Town Court Nursing Center*, 447 U.S., at 786-87), the state does not make the determinative medical decisions here in issue, and the Medicaid patient does not obtain any actionable claim based on state deprivation of property or any other Fourteenth Amendment interest. See discussion, Subpoint B.

Even if private physician and nursing home transfers from higher to lower levels of care are viewed as state imposed restrictions on Medicaid benefits, the patients' 'property interest' thus derived would not be constitutionally protected. "The Court never has held that *any* substantive restriction upon the removal of *any* governmental benefit gives rise to a generalized [protected]

property interest in its continued enjoyment." *O'Bannon* v. *Town Court Nursing Center,* 447 U.S., at 795 (BLACKMUN, J. concurring (emphasis original). The nature of the interest at issue in each case must be examined (Id., at 796, citing *Board of Regents* v. *Roth,* 408 U.S. 564, 577 [1972]), and any claim of entitlement to constitutional protection must depend on expectations that are "'justifiable,' *Vitek* v. *Jones,* 445 U.S., at 489; 'protectible,' *Greenholtz* v. *Nebraska Penal Inmates,* 442 U.S. 1, 7 (1979); 'sufficient,' *Bishop* v. *Wood,* 426 U.S. 341, 344 (1976); or 'proper,' *id.,* at 362 (dissenting opinion)." *Ibid.* The Medicaid patient's only fair expectation when he enters a nursing home is that his level of care will increase or decrease as his condition warrants and that he will be dischaged, or released to a non-medical facility, when he is sufficiently recovered. As appears, this expectation, like that of a privately financed patient, conforms exactly with the purpose and effect of the medical decisions to which he is subject, and no 'justifiable,' 'sufficient' or 'proper' claim of entitlement to due process protection can be invoked against them. See *O'Bannon* v. *Town Court Nursing Center,* 447 U.S., at 796-802 (BLACKMUN, J. concurring), finding no property interest worthy of due process protection in transfers of Medicaid nursing home patients resulting from governmental decertification of the home in which they were patients.

CONCLUSION

For the foregoing reasons, the Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

ROBERT ABRAMS
Attorney General of the State of New York
Attorney for Petitioners
Two World Trade Center
New York, N.Y. 10047
(212) 488-3023

Dated: New York, New York
May 19, 1981

SHIRLEY ADELSON SIEGEL
Solicitor General

JUDITH A. GORDON
MARION R. BUCHBINDER
Assistant Attorneys General
of Counsel

Appendix A—Order of United States Court of Appeals for the Second Circuit Denying Rehearing

UNITED STATES COURT OF APPEALS
SECOND CIRCUIT

At a stated term of the United States Court of Appeals, in and for the Second Circuit, held at the United States Court House, in the City of New York, on the 18th day of February, one thousand nine hundred and eighty-one.

UNITED STATES COURT OF APPEALS
Filed
Feb 18 1981
A. Daniel Fusaro, Clerk
Second Circuit
No. 80-7197

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Plaintiff-Appellees,

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors-Appellees,

v.

BARBARA BLUM, individually and as Acting Commissioner of the New York State Department of Social Services, ROBERT WHALEN, M.D., individually and as Commissioner of the New York State Department of Health,

Defendants-Appellants.

Appendix A

A petition for rehearing containing a suggestion that the action be reheard in banc having been filed herein by counsel for the defendants-appellants, Barbara Blum, et al.

Upon consideration by the panel that heard the appeal, it is

Ordered that said petition for rehearing is DENIED.

It is further noted that the suggestion for rehearing in banc has been transmitted to the judges of the court in regular active service and to any other judge on the panel that heard the appeal and that no such judge has requested that a vote be taken thereon.

/s/ A. Daniel Fusaro
A. DANIEL FUSARO
Clerk

Appendix B—Opinion of the United States Court of Appeals for the Second Circuit

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 1234—September Term, 1979
(Argued June 11, 1980 Decided August 25, 1980)
Docket No. 80-7197

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Plaintiff-Appellees,

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors-Appellees,

v.

BARBARA BLUM, individually and as Acting Commissioner of the New York State Department of Social Services, ROBERT WHALEN, M.D., individually and as Commissioner of the New York State Department of Health,

Defendants-Appellants.

Before:

LUMBARD and MANSFIELD, *Circuit Judges*,
and MEHRTENS, *District Judge*.*

---

* Pursuant to § 0.14 of the Rules of this Court, this appeal is being determined by Judges Lumbard and Mansfield, who are in

(footnote continued on following page)

Appendix B

Appeal from a permanent injunction granted by the District Court of the Southern District, Motley, *J.*, requiring the State of New York to furnish certain procedural safeguards to Medicaid recipients resident in nursing homes prior to transfer. Affirmed in part, vacated in part, and modified.

JOHN E. KIRKLIN, ESQ., Director of Litigation Civil Appeals & Law Reform Unit, The Legal Aid Society, New York, N.Y. (David Goldfarb, Esq., The Legal Aid Society, Bronx, New York and Charles Robert, Esq., Hempstead, New York, of counsel), *for Plaintiffs-Appellees.*

DAVID R. FERGUSON and KENNETH R. THOMAS, Assistant Attorneys General, New York, N.Y. (Robert Abrams, Attorney General of the State of New York, George D. Zuckerman, Assistant Solicitor General, New York, N.Y., of counsel), *for Defendants-Appellants.*

LUMBARD, *Circuit Judge:*

Plaintiffs, certified by the district court as that class of persons receiving New York State Medicaid assistance who are residents of nursing homes, were granted a permanent injunction by the District Court for the Southern District, Motley, *J.*, enjoining state authorities

---

(footnote continued from preceding page)

agreement on this opinion. Judge Mehrtens, Senior District Judge for the Southern District of Florida who was designated to sit on this case and who heard the argument, unfortunately died on July 16, 1980. Although he concurred in the disposition of this case, prior to his death he did not have the opportunity to see this opinion.

and nursing homes from discharging or transfering patients to a different level of care without certain procedural safeguards intended to supplement residents' existing state statutory right to a hearing.[1] Also at issue is the district court's permanent injunction forbidding state officials from reversing a hearing officer decision favorable to a plaintiff class member without having considered the full transcript of the hearing, and the district court's refusal to order the Department of Health, Education and Welfare ("HEW") joined as a party. We affirm the permanent injunction with respect to the due process rights of patients subject to transfer, with some modification; we vacate the district court's injunction with regard to reversals of hearing officer determinations; and we affirm the district court with respect to its refusal to order joinder of HEW.

In the past two decades, government has taken responsibility for caring for the medical needs of the elderly. One result of this has been the creation of a system of nursing homes, owned and run by private individuals or charitable organizations, whose population is made up largely of elderly recipients of state and federal assistance. Nursing homes are classified into two types: skilled nursing facilities (SNF's), and health related facilities (HRF's).[2] The latter provide a lower level of care than the former.

---

[1] At the evidentiary hearing, the patient can challenge his transfer on various substantive grounds derived from state and federal statute and regulations. The most important of these substantive grounds is that his transfer be for "medical reasons".

[2] At the time this case was tried, there were approximately 95,000 nursing home beds in New York state, including approximately 68,000 SNF beds and 27,000 HRF beds. There were 611 nursing homes in the state, of which 291 were SNF's, 30 were HRF's, and 290 were combination SNF-HRF's.

Appendix B

Through HEW regulations, the federal government mandates a procedure called Utilization Review (UR), a kind of patient audit meant to insure that patients are not kept in SNF's longer than necessary, or in any facility when they no longer need medical attention or custodial care. The regulations provide that decisions on such matters are to be made by a Utilization Review Committee (URC), made up, in part, of physicians not financially interested in the affairs of the particular nursing home.

When a patient is transferred from one level of care to another, the State Medicaid authorities review his status and reduce or increase his benefits accordingly and the parties agree that reimbursement rates are "ordinarily" lower for HRF's than for SNF's. A decision to reduce or terminate a patient's Medicaid benefits triggers a federal right (under 42 U.S.C. § 1396(a)(3) and 45 C.F.R. § 205.10) to a hearing, provided by the state. Plaintiffs claimed in this case that the bare right to such a hearing did not meet the requirements of due process, in part because of inherent shortcomings and in part because of the manner in which the state has performed its duty to provide such hearings. In particular the district court found that patients were not given effective written notice of their hearing rights and were not given sufficient access to their medical files to enable them effectively to challenge the transfer decision.

In an earlier appeal, we affirmed, insofar as appealed from, a preliminary injunction granted by the district court ordering certain additional procedural due process safeguards with regard to nursing home transfers, prohibiting the state from delegating to nursing homes the responsibility for notifying patients of their hearing rights, and prohibiting the state from not disclosing to the patient medical information deemed harmful to a patient. *Yaretsky* v. *Blum*, 592 F.2d 65 (2d Cir. 1979).

Appendix B

Before the injunction was made permanent, the parties entered into a consent judgment which embodied most of the procedural safeguards sought by plaintiffs with respect to patient transfers. The consent judgment spelled out the right of the patient or his representative to receive timely notice of the intended transfer; guaranteed the opportunity to have access to all documents in his medical file; made the patient's voluntary permission a prerequisite to transfer; and required that the hearing officer consider a "psychosocial" evaluation of the effect of transfer on the patient.

The consent judgment left several issues of the law to be decided by the district court: (1) are due process protections required (a) when a patient is transferred from a lower to a higher level of care, whether the transfer is initiated by a URC or not, and (b) when a patient transfer to a lower level of care is not initiated by a URC; and (2) are state administrative agency decision-makers required by due process or state law to read a verbatim transcript of the hearing before reversing a hearing officer's determination favorable to a member of the plaintiff class?

The district court found that patients are entitled to due process when transferred fom a lower level of care to a higher one, and when a transfer is initiated by someone other than a URC. We agree because we think such transfers involve state action affecting constitutionally protected property and liberty interests.

The Supreme Court has not defined the limits of state action, but it has supplied the following, somewhat sibylline formula: "the existence of 'state action' depends on 'whether there is sufficiently close nexus between the State and challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself.' " *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974), *quoted in Schlein* v. *Milford Hospital,*

Inc., 561 F.2d 427, 428 (2d Cir. 1977). In *Jackson*, the inaction of a state regulatory commission in failing to veto a clause in a utility's tariff was found insufficient to be state action. In *Schlein*, the action of a private hospital in rejecting a physician's application for staff privileges was held not to be state action.

In the case at bar, however, the state takes a less passive role and responds to the "action" of the "regulated entity". When a nursing home moves a patient from an SNF to an HRF, or when a patient is moved by either the nursing home or a URC to an SNF from an HRF, the state Medicaid authorities adjust the patient's benefits. The state has, in essence, delegated a decision to increase or reduce a public assistance recipient's benefits to a "private" party; but such a delegation cannot prevent due process guarantees from attaching. In *Yaretsky* v. *Blum*, *supra* at 67, we held that the state cannot delegate its due process duty to notify patients of their rights to a hearing.

Appellants argue that when a patient's private physician initiates a transfer of his patient from one level of care to another that cannot be said to be state action. This argument misses the mark, because we do not base our finding of state action on the character of the nursing home industry as a regulated industry, nor on the function of providing health care for the elderly as a non-delegable duty of the state. A private physician's decision to transfer his patient can have the same result as a nursing home's—an alteration in the patient's benefits. Since that is the nexus required by *Jackson* v. *Metropolitan Edison*, and since that exists equally despite the change in identity of the party initiating the transfer, no exception can be made for physician-initiated transfers.

Once it is determined that state action has occurred, the second level of analysis is the identification of a liberty or property interest affected by the state action. In *O'Bannon* v. *Town Court Nursing Home*, 48 U.S.L.W. 4842

(1980), seven justices agreed that nursing home patients did not enjoy a due process right with respect to a decision by HEW to decertify a nursing home. But the *O'Bannon* majority also clearly recognized due process protection for Medicaid patients when the withdrawal of "direct benefits" under Medicaid programs was involved. 48 U.S.L.W. at 4845. These "direct benefits" were characterized by the court as those "essentially financial in character." Thus, in this case, when a patient is transferrd from an SNF to an HRF, or from either an SNF or HRF to an adult home providing no medical care, or is simply discharged, a clear property right entitled to constitutional protection is affected. When a patient is transferred to a higher level of care, there is no similar withdrawal of "essentially financial" "direct benefits." But appellees argue that a patient's interest in avoiding the effects of "transfer trauma" is a constitutionally protected "liberty interest." We agree.

In *OBannon* v. *Town Court Nursing Home,* the majority assumed that "transfer trauma" existed, but reasoned that when such trauma was caused by the action of a third party (i.e., the nursing home) in failing to remain qualified for federal aid, Medicaid recipients did not suffer a "direct" enough injury to make it a deprivation of life, liberty or property. 48 U.S.L.W. at 4845. We do not believe, however, that *O'Bannon* forecloses the question whether there is a liberty interest in avoidance of transfer trauma in this case. The majority's distinction between those rights of Medicaid recipients which are protected by due process ("direct benefits") and those not so protected ("indirect benefits"), in the context of which the majority's rejection of reliance on transfer trauma as denial of a liberty interest occurs, is prefaced by the important qualification: "decertification . . . is not the same for purposes of due process analysis as a decision to trans-

fer a particular patient. . . ." 48 U.S.L.W. at 4845. Moreover, *O'Bannon* was not decided on the basis of a record that included much detailed information about the existence of transfer trauma, see 48 U.S.L.W. at 4849, n.10 (Blackmun, *J.*, concurring in the judgment), although one justice, relying on extra-record studies, was convinced that the medical evidence was "inconclusive." 48 U.S.L.W. at 4850 (Blackman, *J.*, concurring in the judgment). We note that the record in this case contains ample evidence that transfer of elderly patients, even when it does not pose an increased risk of mortality, carries with it the undeniable possibility of emotional and psychological harm—at least in the case of many individuals. To us this does not seem any less a "liberty interest" than a prison inmate's interest in not being transferred from a penitentiary to a psychiatric hospital; which interest was accorded constitutional protection in *Vitek* v. *Jones*, 48 U.S.L.W. 4317 (1980).

Having found that state action and a constitutionally cognizable liberty or property interest exists, it follows that the plaintiffs are entitled to due process. But the question of what process is due them requires further consideration, particularly where, as here, plaintiffs are already given, by statute, the right to a hearing. *Mathews* v. *Eldridge*, 424 U.S. 319 (1976), requires a balancing of private interest, risk of erroneous decision, and administative burdens in formulating the procedural protection required to satisfy due process. We are persuaded that the contours of the relief fashioned by the district court represent an appropriate balancing of the interests recognized in *Mathews*. In essence, the injunction confirms those due process protections already conferred on Medicaid patients by the language of federal and state statutes and regulations already on the books. Under such circumstances, and absent any argument by appel-

lants that the scope of the remedy is too broad, we affirm the district court's injunction under *Mathews*.[3]

Appellants also argue that the district court's refusal to order an appearance by HEW in this case was an abuse of discretion. Since New York State's eligibility for federal funds reimbursing many of the costs of its Medicaid program depends on HEW's determination that state procedures comply with federal regulations, appellants argue that implementation of the court's injunction may jeopardize New York's approved status. Given such a threat, they argue, HEW should have been brought into the case. Whatever the desirability of such participation, see *Yaretsky* v. *Blum, supra* at 70 (Lumbard, *J.*, concurring in part, dissenting in part), we cannot say that the district court abused its discretion. Present in the record in this case is a letter from HEW acknowledging that the post-injunction state of affairs poses no compliance problem for HEW. However, we think it best to modify the injunction to include a provision that if at any time in the future HEW determines that the procedures mandated by this injunction make New York State wholly or partially ineligible for Medicaid reimbursement funds, upon application, the district court shall vacate the injunction.

Finally we reach the question of the district court's decision that a decision-maker's failure to rely on hearing transcripts violates the Fourteenth Amendment of the United States Constitution and New York law. We hold

---

[3] We note that the October 17, 1979 partial final judgment embodying the parties' consent agreement contains procedural protections for patients subject to UR-initiated transfer considerably more extensive than those granted to patients subject to non-UR transfer under the partial final judgment of February 19, 1980. Only the latter has been appealed, and thus we have no occasion to deal with whether or not the protections embodied in the October 17 stipulations are required by due process or satisfy the principles of *Mathews* v. *Eldridge, supra*.

that neither the Constitution nor New York law requires the administrative decision-maker in an appeal from a hearing officer recommendation to read (or listen to) the entire transcript (or tape recording) of the hearing before issuing an administratively final decision, whether favorable or adverse to the claimant. Accordingly, we vacate the district court's injunction insofar as it affected the state's administrative practice in this regard.

Patients about to be transferred have the right, under federal statute and regulations, 42 U.S.C. § 1396(a)(3) and 45 C.F.R. § 205.10, to a "fair hearing" provided by the state. This hearing is conducted by a hearing examiner who listens to the testimony, prepares a summary, and makes a recommendation to the Commissioner. Although the parties sharply disagree as to whether or not the hearing officer is empowered to make findings of fact, we do not find that issue controlling and do not decide it. The parties agree that the stenographic or electronic transcript of the hearing is sent to the Department of Social Services in Albany, and that the Commissioner's designees who are responsible for deciding the case do not listen to a tape of the hearing, and that no transcript of the hearing is made prior to their decision. (The chief purpose of the state statutory requirement that a complete electronic or stenographic record of the hearing be kept appears to be to allow judicial review in a proceeding under N.Y.C.P.L.R. Article 78). The Commissioner's designees follow a set of ten detailed criteria in deciding whether to approve or disapprove the hearing officer's recommendation. If he feels the need, the designee may consult the electronic or stenographic record, but the parties agree that state policy does not require the designee to do so.

We believe that, insofar as federal law is concerned, this issue is governed by *National Nutritional Foods Assoc.* v. *FDA*, 491 F.2d 1141 (2d Cir. 1974). In *National Nutri-*

tional, an FDA regulation was challenged on the ground that the Commissioner who signed the order involved could not possibly have reviewed and considered objections to the proposed rule because of their volume during the short period he had been in office at the time he approved the regulation. Like appellees in this case, petitioners in *National Nutritional* relied on *Morgan* v. *United States*, 298 U.S. 468 (1936) (Morgan I), which contains the familar phrase "The one who decides must hear." *Id.* at 481. But, as Judge Friendly's opinion in *National Nutritional* observes, "the life of this aspect of Morgan I was extremely brief. In Morgan IV [*United States* v. *Morgan*, 313 U.S. 409 (1941)] Mr. Justice Frankfurter, writing for a Court unanimous on this point, took back most or all of what the first decision had given." 491 F.2d at 1144.

Even the Morgan I case cannot be said to go as far as appellees would argue. As Professor Kenneth Culp Davis has written:

> Since the only purpose of sifting and analyzing of evidence by subordinates is to save the time of the deciding officers, this necessarily means that deciding officers may "consider and appraise" the evidence by reading a summary or analysis prepared by subordinates. The Supreme Court thus did not require in the First Morgan case that deciding officers must read all the evidence or even that they must directly read any of it. The requirement has to do with personal understanding of the evidence, not with the mechanics by which the understanding is developed. In common practice, deciding officers develop their understanding of evidence not only through reports of subordinates but especially through summaries and explanations in briefs. . . .

2 Davis, Administrative Law § 11.03 at 44-45 (1958) (footnotes omitted). See also *Bates* v. *Sponberg*, 547

F.2d 325 (6th Cir. 1976) (no violation of due process when decision-making body voted on appeal from an administrative adjudication without reading the transcript, relying on summary report).

Under Morgan IV and *National Nutritional,*[4] an administrative official to whom a decision has been delegated is immune from judicial inquiry "as to the extent of his investigation and knowledge of the points decided, or as to the methods by which he reached his determination."[5] *National Nutritional, supra,* 491 F.2d at 1145, quoting *DeCambra* v. *Rogers,* 189 U.S. 119, 122 (1903). The reasons for this rule derive from the extended, complex nature of the administrative decision-making process, *see Citizens to Preserve Overton Park, Inc.* v. *Volpe,* 401 U.S. 402, 422-23 (1971) (Blackmun, *J.,* concurring), the difficulty of seeing into the decision-maker's mind, and the enormous volume of administrative decisions which must be made each year. Although, for example, only about 600 appeals from nursing home transfer cases are decided each year

---

[4] In *National Nutritional,* our opinion emphasized that the "presumption of regularity" in the actions of administrative decision-makers is especially appropriate "in the context of the promulgation of legislative rules as distinguished from adjudication." 491 F.2d at 1145. The resolution of appeals in nursing home transfer cases is, of course, administrative action of an adjudicative rather than rule-making type. We see, however, no reason for adopting a different rule in the adjudicative context. Under *Mathews* v. *Eldridge, supra,* the administrative burden on the state may be given weight in determining the boundaries of due process protection in both adjudicative and rule-making proceedings; indeed, *Mathews* itself involved an adjudication. *Bates* v. *Sponberg,* 547 F.2d 325 (6th Cir. 1976) also involved an adjudication.

[5] An exception to this general principle exists where there is a showing of misconduct on the part of the agency. *See, e.g., Singer Sewing Machine Co.* v. *N.L.R.B,* 329 F.2d 200, 206-08 (4th Cir. 1964).

in New York State, approximately 68,000 appeals in welfare benefit adjustment cases must be decided in the same period in New York. Such a large administrative burden is an important factor in determining what kind of due process protection must be accorded the subjects of administrative decision-making. *Mathews* v. *Eldridge*, 424 U.S. 319, 335 (1976).[6]

Appellees also argue that New York law prohibits the administrative practice at issue, citing *La Valle* v. *Blum*, 67 A.D.2d 708 (App. Div. 2d Dept. 1979), *Anderson* v. *Toia*, 59 A.D.2d 1024 (App. Div. 4th Dept. 1977), *Halley* v. *Lavine*, 47 A.D.2d 945 (2d Dept. 1975), *Cruz* v. *Lavine*, 45 A.D.2d 720 (App. Div. 2d Dept. 1974). Some of these intermediate appellate memorandum opinions are distinguishable on their facts; for example, in *Anderson*, *supra*, the fatal defect in administrative procedure seems to have been the fact that "the recording tape ran out" during the recording of the hearing, rather than that the agency decision-maker failed to listen to the tape. And *La Valle* v. *Blum*, *supra*, is most fairly read as standing for the principle that where an agency determination rests on certain facts which are incorrect and which can be found in correct form in a transcript unread by a decision-maker, a court will grant relief under N.Y.C.L.R. Art. 78. But *Halley* v. *Lavine*, *supra*, does unequivocally hold that ad-

---

[6] Appellees rely also on *Ostrowski* v. *City of New York*, 601 F.2d 629 (2d Cir. 1979), which involved a due process challenge to the decision-making procedures used by the Department of Sanitation in disciplinary cases. But the remarks we made concerning federal due process issues raised by the Department's practices in *Ostrowski* were dictum, since the case was remanded for findings on state law issues. In any event, as the *Ostrowski* opinion notes, the decision-maker in that case "did not have a complete record of hearing." *Id.* at 631. As noted above, the decision-makers in nursing home transfer cases have available to them the complete record of the hearing.

ministrative decision-makers must hear or read verbatim transcripts or recordings of fair hearings. *Accord, Cruz* v. *Lavine, supra.* Whether these memorandum decisions represent a developing trend among New York's intermediate appellate courts is something the future will reveal.

Appellants argue that controlling decisions of the New York Court of Appeals unequivocally show that there is no state law requirement that decision-makers read transcripts, whatever the status of lower court decisions possibly in conflict with the Court of Appeals cases. The first of these cases, *Matter of Weekes* v. *O'Connell,* 304 N.Y. 259, 107 N.E.2d 290 (Ct. App. 1952), offers little support to appellants. In *Weekes,* the State Liquor Authority adopted and affirmed a hearing officer's decision in a license revocation case within an hour of the conclusion of the hearing, before the hearing had been transcribed. The Court of Appeals, in an opinion by Chief Judge Fuld, held the Authority's decision invalid. Seven years later, however, in *Matter of Taub* v. *Pirnie,* 3 N.Y.2d 188, 144 N.E.2d 3 (Ct. App. 1957), the Court of Appeals, again in an opinion by Chief Judge Fuld, limited *Weekes'* significance. *Taub* involved a challenge to a decision by a Zoning Appeals board based on the fact that one member of the board had voted without reading a transcript of the hearing held in the case. Judge Fuld wrote:

> Courts, we have said, will not " 'probe the mental process' " of the members of an administrative tribunal. Absent a showing, "clearly reveal[ed]," that "they made no independent appraisal and reached no independent conclusion," we will not disturb the decision. As we wrote in the *Weekes* case, "the extent to which independent study of the evidence in the record is necessary to the required exercise of informed judg-

ment must be left to the wisdom and practical good sense of the commissioners themselves" . . . .

3 N.Y.2d at 193-94.

In the Court of Appeals' most recent case in this series, *Matter of Wallace* v. *Murphy*, 21 N.Y.2d 433, 235 N.E.2d 759 (Ct. App. 1968), involving disciplinary action against a police officer, the Court reiterated its adherence to the *Taub* doctrine that what is required by law (absent specific statutory provisions requiring more) is only an informed decision, and confirmed *Taub's* interpretation of *Weekes* as resting on the Liquor Authority's violation of its own rules and regulations. *Id.* at 438. *Wallace* further held that where state law requires a full transcript to be made, that transcript must be "available" to the decision-maker. But *Wallace* does not hold, and we think the implication is fair that it holds to the contrary, that the decision-maker must take advantage of the transcript's availability in any manner more specific than that required to satisfy *Taub's* mandate of an exercise of "informed judgment".

The Department of Social Services' present practices, as the parties have stipulated, clearly comport with state law requirements that administrative decision-making be an exercise of "informed judgment." The use of the detailed criteria followed by the Department indicate that the decision-maker does much more than rubber-stamp the hearing officer recommendation, and his reliance on summaries and other material prepared by the hearing officer satisfies the state law requirement that his judgment be informed. Moreover, it is clear that *Wallace's* requirement that where transcripts exist they be available to the decision-maker is satisfied by the Department's practices. The parties have agreed that the electronic recordings of

the hearings are forwarded to the Department in Albany, where the decision-maker works. The Department's policy is to have its decision-makers review the electronic transcript only if they feel it would be useful. This practice establishes that the decision-makers have the transcripts "available" in the sense required by *Wallace*.

Accordingly, we reject appellees' argument that state law requires administrative decision-makers to read or listen to complete transcriptions or recordings of hearings before reversing hearing officer recommendations favorable to recipients of benefits conferred by the state.

Affirmed in part, vacated in part, and modified.

Appendix C—Partial Final Judgment of the United States District Court for the Southern District of New York

Civil Action No.
76 Civ. 3360 (CBM)
PARTIAL FINAL JUDGMENT

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

WILLIAM YARETSKY, *et al.*,

Plaintiffs,

and

MARY FOLEY, *et al.*,

Plaintiffs-Intervenors,

against

BARBARA BLUM, *et al.*,

Defendants.

The Court on October 17, 1979 having ordered the entry as a partial final judgment of the consent stipulation signed by attorneys for the parties on May 29, 1979 together with the Addendum Concerning Monitoring signed on October 17, 1979, and several legal issues having been reserved in the partial final judgment for judicial determination, and the Court having issued a memorandum opinion on October 17, 1979, granting summary judgment in favor of the plaintiffs on the reserved legal isues, it is hereby

ORDERED, ADJUDGED and DECREED (1), pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure, that the plaintiff class in this action is defined as all Medicaid recipients in the State of New York who are residents of

skilled nursing facilities or health-related facilities in the State; and it is further,

ORDERED, ADJUDGED and DECREED (2), pursuant to Rule 56 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2201, that the defendants' failure to provide advance adequate notice in writing and the opportunity for a prior evidentiary hearing for each plaintiff class member whom the nursing facility in which he/she resides intends to discharge, transfer to a lower level of nursing care, or transfer to a higher level of nursing care is unlawful under the Due Process Clause of the Fourteenth Amendment; and it is further,

ORDERED, ADJUDGED and DECREED (3), pursuant to Rule 56 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, that action of the defendant State Commissioner of Social Services and her authorized agent in rendering a fair hearing decision unfavorable to a plaintiff class member without first obtaining, reading, and adequately considering a verbatim transcript of the fair hearing, together with all exhibits at the hearing, is unlawful under the Due Process Clause of the Fourteenth Amendment and New York State Law; and it is further,

ORDERED AND ADJUDGED (4), pursuant to Rule 65 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, that the defendants, their officers, agents, employees, successors in office and all persons in active concert and participation with them (including all skilled nursing and health-related facilities in New York State) be and hereby are permanently enjoined, in the case of any plaintiff class member, from permitting or taking the action of discharging the patient, transferring the patient to a lower level nursing care, or transferring the patient to a higher level of nursing care without the provision by the defendants or their authorized employees of (a) written notice to the af-

fected patient a reasonable period in advance of the proposed action setting forth in adequate detail at least a description of the proposed action and a full explanation of the individual's right to obtain a prior evidentiary state agency hearing to contest the proposed action, and (b) the opportunity for the affected patient to have an evidentiary state agency hearing in advance of the proposed action on the issue of the validity and appropriateness of the proposed action pursuant to applicable federal and state statutory and regulatory provisions (including, but not limited to 42 C.F.R. §§ 405.1121(k)(4) and 442.311(c)); and it is further,

ORDERED AND ADJUDGED (5), pursuant to Rule 65 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, that the defendant State Commissioner of Social Services, her officers, agents, employees, and successors in office be and hereby are permanently enjoined from rendering a fair hearing decision unfavorable to any plaintiff class member without first obtaining, reading, and adequately considering a verbatim transcript of the fair hearing, together with all exhibits at the hearing; and it is further,

ORDERED (6) that the issue of plaintiffs' entitlement to an award of reasonable attorneys' fees, expenses, and costs herein is reserved for later determination by this Court, upon appropriate motion.

/s/ Constance Baker Motley
CONSTANCE BAKER MOTLEY,
U.S.D.J.

Dated: New York, New York
December 13, 1979

Appendix D—Endorsement of the United States District Court for the Southern District of New York

Endorsement

The court holds that as to both non-UR transfers out of a facility or to a lower level of care and as to UR transfers to higher levels of care there is a due process right to a hearing, state action being involved in both instances for all of the reasons set forth in plaintiffs' memorandums of law on these questions and that it is settled law that a verbatim transcript is required. Submit order.
New York, N.Y. 10/17/79

/s/ Constance Baker Motley
U.S.D.J.

Office - Supreme Court, U.S.
FILED
DEC 2 1981
ALEXANDER L. STEVAS,
CLERK

No. 80-1952

IN THE
Supreme Court of the United States
OCTOBER TERM, 1981

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, M.D., as Commissioner of the New York State Department of Health,

Petitioners

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

JOINT APPENDIX

ROBERT ABRAMS
Attorney General of the State of New York
Two World Trade Center
New York, New York 10047
(212) 488-2462

SHIRLEY ADELSON SIEGEL
Solicitor General
JUDITH A. GORDON
ANDREA G. IASON
Assistant Attorneys General

Counsel for Petitioners

JOHN E. KIRKLIN
The Legal Aid Society
Civil Appeals & Law Reform Unit
11 Park Place
New York, New York 10007
(212) 227-2755

KALMAN FINKEL
Attorney-in-Charge
DAVID GOLDFARB
CHARLES ROBERT

Counsel for Respondents

Petition for Certiorari Filed May 19, 1981
Certiorari Granted October 5, 1981

TABLE OF CONTENTS

	PAGE
Relevant Docket Entries in the United States District Court for the Southern District of New York	1
Relevant Docket Entries in the United States Court of Appeals for the Second Circuit	17
First Amended Complaint	19
Answer to Amended Complaint	35
November 30, 1977 Order to Show Cause Joining Plaintiffs-Intervenors Wolper, Shulman, Rossoff and Ashkenazy and Issuing Temporary Restraining Order	40
December 13, 1977 Order to Show Cause Joining Plaintiffs-Intervenors Birenzweig, Zahl, Kolman, J. Lundy and P. Lundy, Certifying Class and Issuing Temporary Restraining Order for All Intervenors	43
Intervenor Complaint—Foley (Excerpts)	47
Intervenor Complaint—Wolper, Shulman, Rossoff, Ashkenazy (Excerpts)	55
Intervenor Complaint—Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy (Excerpts)	74
January 4, 1978 Hearing (Excerpts)	92
January 5, 1978 Order Issuing Preliminary Injunction and Dismissing Action Against City Defendant	99
January 10, 1978 Opinion on Preliminary Injunction, Class Certification and Dismissal of City Defendant	104

PAGE

February 17, 1978 Order Denying State Defendants Relief From January 5, 1978 Order Requiring Them To Notify Patients Of Adverse Utilization Review Committee Decisions 121

January 16, 1979 Opinion of the Court of Appeals .. 122

Deposition of Anthony J. Maddaloni (Excerpts) ... 134

March 5, 1979 Pretrial Order (Excerpts) 150

Notice of Motion for Summary Judgment 209

Plaintiffs' Rule 9(g) Statement 212

Affidavit of Philip M. Gassel 213

Affidavit of Kenneth A. Thomas in Support of Motion to Join HEW as a Defendant and in Opposition to Motion for Summary Judgment 216

Affidavit of Kenneth A. Thomas in Opposition to Motion for Summary Judgment 223

Defendants' Rule 9(g) Statement 226

October 17, 1979 Partial Final Judgment 227

October 17, 1979 Memorandum Opinion Endorsed .. 240

December 13, 1979 Partial Final Judgment 241

Notice of Appeal 244

August 25, 1980 Opinion of the United States Court of Appeals 245

February 18, 1981 Order of the United States Court of Appeals Denying Rehearing 260

Relevant Docket Entries in the United States District Court for the Southern District of New York

76 Civ. 3360 W. Yaretsky, et ano. v Phillip Toia [& Robert Whalen] [as amended 4-8-77] MOTLEY, J.

DATE	DOC. NO. [RECORD ON APPEAL]*	PROCEEDINGS
7-28-76	(1)	Filed complaint and issued summons . . .
		* * *
11-4-76	(3)	Filed marshal's return—served the following: Philip Toia by John Wylie on 10-26-76 J. Raymond Diehl by John Wylie on 10-26-76
		* * *
12-13-76	(4)	Filed ANSWER of defts. to the complaint. (L.J.L.)
		* * *
4-7-77	(6)	Filed pltff's (Ralph Cuevas) affdvt. to proceed in forma pauperis.
4-7-77	—	Filed memo endorsed on document #6 —that said pltff. is permitted to proceed in forma pauperis. MOTLEY, J.
		* * *
4-8-77	(8)	Filed first AMENDED COMPLAINT—issued summons.

---

* The writ of certiorari granted in part by this Court on October 5, 1981 refers to an appeal designated by docket number 80-7197 in the United States Court of Appeals for the Second Circuit. The numbers in parentheses and brackets correspond with the document numbers in the 80-7197 Second Circuit record on appeal which will be transmitted to this Court. See Rules 23(2) and 30(2) of the Supreme Court Rules. The 80-7197 record on appeal includes records on appeal in earlier and later Second Circuit appeals in the same case which were designated as 78-7077 (earlier appeal, adjudicated) and 80-7559 with cross appeal 80-7625 (later appeals, withdrawn). Documents for the several appeals are identified by Second Circuit docket number when necessary to enhance clarity.—ED.

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
4-13-77	(9)	Filed Order that pltff. William Yaretsky is permitted to proceed in forma pauperis, etc. MOTLEY, J. (m/n)
		• • •
5-23-77	(10)	Filed ANSWER of defts. to the Amended Complaint. (L.J.L.)
		• • •
12-5-77	[12]	Filed Order to Show Cause with proposed intervenor complaint to show cause, temporary restraining order and joinder order, for preliminary injunction, etc. ret. 12-8-77. MOTLEY, J.
12-14-77	[13]	Filed [intervenor] complt.—class action [Birenzweig, etc.].
12-14-77	[14]	Filed brief in support of motion of pltff. for certification of subclass.
12-14-77	[15]	Filed Order to Show Cause for order to intervene, class certification and temporary restraining order ret. 12-20-77 at 2 PM. MOTLEY, J.
1-3-78	[16]	Filed affidavit of deft. in opposition to application for preliminary inj.
1-3-78	[17]	Filed affidavit of deft. in opposition to motion for preliminary inj.
1-5-78	[18]	Filed deft. Dept. of Health (Office of Health Systems Management) affidavit re: utilization review committee, etc. by DONALD B. DAVIDOFF, Asst. Dirc. of the Facility Surveillance Group.
1-5-78	[19]	Filed deft. New York State Department of Social Services affirmation

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
		in opposition to pltffs.' motion for class certification and a preliminary injunction by PETER MULLANY.
1-5-78	[20]	Filed deft. New York State Dept. of Social Services (Div. Medical Assistance) affidavit in opposition to pltffs.' motion for class cert. & prelim. injunc. by WILLIAM STEIBEL.
1-5-78	[21]	Filed state defts.' memorandum of law in opposition to pltffs.' motion for prelim. injunciton and class certification.
1-4-78		Hearing begun.
1-5-78		Hearing concluded. Judge issued preliminary inj. Opinion to be written from oral record.
		• • •
1-10-78	[23]	Filed Order that pursuant to Rule 21 FRCP above-entitled action is dismissed as against deft. J. HENRY SMITH and that defts. Barbara Blum, individually etc. et al. are enjoined and restrained pending a final determination of the action from determining [the transfers] any of the pltffs.-intervenors in this action, etc. as indicated. MOTLEY, J. m/n
1-10-78	[24]	Filed Opinion No. 46745 re: motion for preliminary injunction, motion for intervention, motion for class action determination, motion to dismiss. For all the foregoing reasons, an injunction will therefore issue enjoining defts., pending a final determination of this action. First, defts. will be

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
		enjoined, etc. as indicated. What pltffs. actually seek is certification of sub-class. For purposes of this motion for preliminary injunction, . . . that certification is granted etc. as indicated. The city deft.'s motion to dismiss is . . . granted. MOTLEY, J. m/n
1-11-78	[25]	Filed Order that in accordance with court's opinion the instant action is certified as a class action, all intervenor petitions are granted, and deft. J. Henry Smith, Commissioner of Social Services, NYC is dismissed from this action as a pty-deft. So Ordered, MOTLEY, J. m/n
1-16-78	[26]	Filed INTERVENOR COMPLAINT — Class action. (Rec'd this date.) [Foley]
1-16-78	[27]	Filed INTERVENOR COMPLAINT — Class action. (Rec'd this date.) [Wolper, etc.]
1-19-78	[28]	Filed deft. notice of motion and affidavit for order to amend Court order of 1-5-78 ret. 1-19-78 at 4:30 PM.
1-23-78	[32]	Filed memo end. on #29 . . . order will remain as is until new forms are submit[ted by] state defts. So ordered. MOTLEY, J.
1-27-78	[29]	Filed defts.' supplemental affidavit in support of motion to amend order dated 1-5-78.
2-6-78	[30]	Filed pltffs.' affidavit in opposition to defts.' present motion for amendment of partial stay of Court's order etc., by PHILIP M. GASSEL.

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
2-6-78	[31]	Filed NOTICE OF APPEAL [in 78-7077] of defts. Blum and Whalen to USCA 2nd Circuit from order dated 1-5-78 and opinion filed 1-10-78 granting pltffs.' motion for a preliminary injunction, etc. * * *
2-21-78	[29]	Filed memo end. . . . motion to amend order to permitting notice to be sent etc. denied. So ordered, MOTLEY, J. m/n
3-14-78	[33]	Filed transcript of proceedings dated 1-5-78.
2-17-78		PRE-TRIAL CONFERENCE HELD BY MOTLEY, J.
3-24-78	[34]	Filed notice to docket clerk of transmission of record to USCA [in 78-7077].
3-31-78	[35]	Filed defts.' objections to notice to produce.
4-17-78	[36]	Filed pltffs.' notice of motion and affidavit for order granting summary judgment ret. 4-24-78.
4-17-78	[37]	Filed pltffs.' memo in support of motion for partial summary judgment.
4-19-78	[38]	Filed pltffs.' 1st notice to produce.
4-20-78	[39]	Filed pltffs.' affidavit and notice of motion for an order to compel production of documents. ret. April 25th, 1978.
4-20-78	[40]	Filed pltffs.' memorandum of law in support of motion to compel production of documents.

* * *

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
5-8-78	[42]	Filed defts.' memo of law in opposition to pltffs.' motion for partial summary judgment.
5-8-78	[43]	Filed [affidavit] of J. Levy in opposition to motion for pltffs. for summary judgment.
5-8-78	[44]	Filed order compelling discovery and protective order. MOTLEY, J. Pltffs. are to recover reasonable attny's fees in connection with this matter etc. MOTLEY, J.
5-26-78	[45]	Filed transcript of record of proceedings dated 1-4, 5,-78.
5-26-78	[46]	Filed notice of transmission of 1st supplement to record on appeal [in 78-7077].
6-1-78	[47]	Filed defts.' objections to notice to produce.
6-2-78	[48]	Filed pltffs.' affidavit re: attny's fees in Rule 37 motion.
6-2-78	[49]	Filed pltffs.' reply memo in support of motion for summary judgment.
6-7-78	[52]	Filed pltffs.' affidavit and notice of motion for an order to compel production of documents, etc. ret. 6-7-78.
6-7-78	[53]	Filed pltffs.' memorandum in support of motion to compel production of documents.
6-7-78	[51]	Filed pltffs.' notice of motion for order to modify order of 5-4-78 . . . ret. 6-7-78.

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
6-6-78	[50]	Filed pltffs.' 2nd notice to produce.
6-15-78	[54]	Filed memorandum opinion #47307 re: the . . . award attorneys' fees to pltffs. in the amount of $1,260 etc. pur[suant to] FRCP 37 [a][4]. MOTLEY, J. m/n
6-21-78	[55]	Filed Order modifying the order of May 4, 1978 compelling discovery. MOTLEY, J. m/n.
6-21-78	[56]	Filed Order compelling the production of documents, protective order and order pursuant to FRCP Rule 37 (d). MOTLEY, J.
6-28-78	[57]	Filed stipulation that the following documents become part of the record on appeal [in 78-7077].
6-28-78	[58]	Filed notice of transmission of 2nd supplemental . . . record on appeal [in 78-7077].
7-5-78	[59]	Filed Opinion #47,385 . . . pltffs.' motion for declaratory judgment is granted . . . Motion for injunctive relief is denied . . . Submit order on notice and within 5 days of filing this opinion. MOTLEY, J. m/n
7-14-78	[60]	Filed defts.' notice of appeal to USCA from orders of J. Motley dated 6-15-78 and 6-21-78
		• • •
7-17-78	[61]	Filed defts.' memo of law in support of defts.' motion to vacate.
7-17-78	[62]	Filed pltffs.' notice of motion and affidavit for order awarding attny's fees to pltffs. ret. 8/1/78.

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
7-28-78	[63]	Filed pltffs.' memo in opposition to defts.' motion to vacate awards.
		* * *
8-7-78	[65]	Filed Partial Judgment . . . ordered that deft. Whalen formally promulgate the statements contained in Hospital Memo 77-9, 77-10 and 77-13 [as] required by State Adm. Procedure Act, etc. and that pltffs.' motion for inj. relief is denied with leave to renew. MOTLEY, J. Judgment ent. 8-7-78 Clerk.
8-15-78	—	Filed memo end on #6[2] . . . motion denied for all reasons urged by pltffs. So Ordered, MOTLEY, J. m/n.
		* * *
8-23-78	[66]	Filed pltffs.' first interrogs.
9-11-78	[67]	Filed pltffs.' notice of motion to impose sanctions for failure to comply with orders to compel production . . .
9-11-78	[68]	Filed pltffs.' memorandum in support of motion to impose sanctions . . .
9-12-78	[69]	Filed true copy of USCA order withdrawing appeal [doc. no. 60] with prejudice.
9-18-78	[70]	Filed deft. Atty General, State of New York's affidavit in opposition to pltffs.' motion to impose sanctions by: KEVIN J. MCKAY.
9-19-78		Filed memo endorsed on document No. 6[7] . . . Defts. have until 10-16-78 to fully comply with previous orders to produce. For failure to do so, sanctions will be imposed. So Ordered, MOTLEY, J. m/n

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
9-21-78	[71]	Filed pltffs.' third notice to produce.
		* * *
2-8-79	[74]	Filed true copy of USCA Order and opinion [in 78-7077] that judgment of U.S. Dist. Ct. is affirmed in accordance with the opinion of this Court with costs to be taxed against the appellants. JUDGMENT ENTERED — 2-8-79 — CLERK — ent. 2-9-79.
3-5-79	[75]	Filed pltffs.' pre-trial memorandum.
3-6-79	[76]	Filed Pre-Trial Order. MOTLEY, J.
4-3-79	[77]	Filed memo end. on letter to Judge Motley dtd. 3-23-79 — The foregoing proposed amendments to the last pre-trial order and stay are hereby granted. MOTLEY, J.
		* * *
9-14-79	[80]	Filed pltffs.' notice of motion for summary judgment ret. 9-21-79.
9-14-79	[81]	Filed pltffs.' memorandum in support of pltffs.' motion for summary judgment.
9-21-79	[82]	Filed pltffs.' supplemental affidvt. by P. M. Gassel in support of pltffs.' motion that court enter the parties' stip. of consent to entry [of] a partial final judgment.
9-24-79	[83]	Filed memo end. on letter to Judge Motley, dtd. 9-21-79—Defts.' Order to Show Cause will be heard together with pltffs.' outstanding motion on 10-15-79 at 2:00 pm. MOTLEY, J. m/n.
10-1-79	[84]	Filed pltffs.' supplemental memorandum in opposition to defts.' OSC and

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
		in further support of pltffs.' motion for final judgment.
10-3-79	[85]	Filed memo end. on defts.' Order to Show Cause why an order should not be made joining the U.S. Dept. of HEW as a party . . . — After hearing on 10-3-79, both sides present, the court denied the application of the defts. to make HEW a party to this action. The motion for summary judgment which was filed by pltffs. on 9-14-79 will be heard on 10-17-79 at 4:30 p.m. The defts. are directed to serve and file an ans. to the motion on 10-10-79. The pltffs. shall serve and file . . . on or before 10-15-79. . . . MOTLEY, J. m/n.
10-10-79	[86]	Filed defts.' affdvt. of K.A. Thomas in opposition to pltffs.' motion for summary judgment.
10-10-79	[87]	Filed defts.' memorandum of law in opposition to pltffs.' notice of motion.
10-15-79	[88]	Filed pltffs.' reply memorandum in support of summary judgment.
10-19-79	[89]	Filed PARTIAL FINAL JUDGMENT — Ordered that the stip. of consent to entry of partial final judgment, with addendum concerning monitoring, annexed hereto is the judgment of this Ct. MOTLEY, J. JUDGMENT ENTERED 10-19-79—CLERK ent. 10-22-79. m/n
10-19-79	—	Filed memo end. on doc. #8[2]—The Court holds that as to both . . . transfers out of a facility or to a lower

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
		level of care and as to U R transfers to higher levels of care there is a due process right to a hearing, state action being involved in both instances for all of the reasons set forth in pltffs.' memorandum of law on these question[s] and that it is settled law that a . . . transcript is required. Submit Order. MOTLEY, J. m/n
10-17-79	*[96]	Filed deposition/examination before trial of Henry Stevenson witness on behalf of the defts., taken by pltffs. on 11-21-78.
10-17-79	*[97]	Filed deposition/examination before trial of Philip Nostramo, witness on behalf of the defts., taken by pltffs. on 12-5-78.
10-17-79	*[98]	Filed deposition of Anthony J. Maddaloni taken by pltffs. on 10-26-78.
10-17-79	*[99]	Filed deposition of New York State Dept. of Social Services, by Richard Ruid taken by pltffs. on 10-27-78.
10-17-79	*[101]	Filed deposition of non-party witness David Glasser, taken by pltffs. on 11-20-78.
10-17-79	*[100]	Filed deposition of Roger C. Herdman, M.D., taken by pltffs. on 12-15-78.
11-19-79	*[95]	Filed pltffs.' deposition of the non-party witness Elizabeth Dinehart on 11-22-78.

* Numbers in brackets preceded by an asterisk correspond with the document numbers in the first supplemental record on appeal to the United States Court of Appeals for the Second Circuit in 80-7179.—ED.

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
2-14-80	[90]	[Filed] PARTIAL FINAL JUDGMENT—Ordered that the pltff. class in this action is defined as all Medicaid recipients in the State of N.Y. . . . Ordered that deft. State Commissioner of Social Services and her authorized agents are perm. inj. and that the defts., their officers, et al. are perm. inj. . . . as indicated . . . and that the issue of pltffs.' entitlement to an award of reasonable atty's fees, expenses and costs is reserved for later determination by this Court upon appropriate motion. MOTLEY, J. JUDGMENT ENT. 2-19-80—CLERK—ent. 2-20-80. m/n
3-7-80	[91]	[Filed] defts.' notice of appeal to USCA for the 2nd Circuit [in 80-7197] from partial final judgment ent. 2-14-80 granting summary judgment in favor of pltffs. on the reserved legal issues. (3-10-80 mailed copies to PHILIP M. GASSEL, Legal Services, 2095 Broadway, Rm 304., New York, N.Y. 10023., Charles Robert, Nassau Action Coalition, 40 Washington Street, Hempstead, New York 11550., Kalman Finkel, 11 Park Place 8th Floor, New York, N.Y. 10007., David Goldfarb, 953 Southern Blvd., Bronx, N.Y. 10459., Joan Mangones, Ann Moynihan, 42 Richmond Terrace, Staten Island, N.Y. 10310.)
—	*[102]	Clerk's certificate for first supplemental record on appeal. Entry omitted by district court.—ED.°

° Document number [102] concludes the record on appeal and first supplemental record on appeal to the United States Court of Appeals for the Second Circuit in 80-7197.

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
3-27-80	103	[Filed] pltffs.' brief in support of its motion for supplemental order and inj. and for finding of civil contempt.
3-27-80	104	[Filed] pltffs.' affdvt. and notice of motion for supplemental order and inj. and for finding of civil contempt.
4-8-80	105	[Filed] notice that original record on appeal [in 80-7197] has been cert. and trans. to the U.S.C.A. for the 2nd. Circuit, this day.
4-15-80	106	[Filed] defts.' affdvt. and notice of cross motion for stay pending appeal [in 80-7197] ret. 4-16-80.
4-15-80	106	[Filed] defts.' affdvt. by K.A. Thomas in opposition to pltffs.' motion for supplemental order and inj.
4-15-80	107	[Filed] defts.' brief in opposition to pltffs.' motion for supplemental order and for finding of civil contempt and in support of defts.' cross motion for stay pending appeal.
4-16-80	108 †[108]	[Filed] motion by attys for proposed intervenors to intervene as defts. . . . ret. 4-16-80.
4-16-80	109 †[109]	[Filed] memorandum in support of motion to intervene.
4-18-80	110	[Filed] pltffs.' reply and ans. brief in further support of pltffs.' motion for

† Numbers in brackets preceded by † correspond with the document numbers in the record on appeal to the United States Court of Appeals for the Second Circuit in 80-7559 (with cross-appeal 80-7625). The 80-7559 record on appeal contains District

(footnote continued on following page)

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
		supplemental order and inj. and for a finding of civil contempt.
		• • •
4-18-80	113 †[112]	[Filed] defts.' demand for hearing with respect to pltffs.' motion dtd. 3-25-80 and order finding defts. in civil contempt.
5-7-80	114	[Filed] pltffs.' notice of motion for additional supplemental order and injunction.
5-7-80	115	[Filed] pltffs.' brief in support of . . . motion for additional supplemental order and inj.
5- 9-80	116 †[113]	[Filed] Order that the motion of the applicants for intervention to intervene as parties deft. . . . is granted and that deft-intervenors are to submit their papers in opposition to pltffs.' motion by 5-15-80. MOTLEY, J. m/n
5-15-80	117	[Filed] deft-intervenors' brief in opposition to pltffs.' motion.
5-15-80	118	[Filed] deft-intervenors' affdvt. by M. Rosenblatt.

(footnote continued from preceding page)

Court proceedings which are subsequent to the judgment on appeal in 80-7197. The Clerk of the Court of Appeals, nonetheless marked the 80-7559 record on appeal as the second supplemental record on appeal in 80-7197. He will be asked to transmit the 80-7559 record on appeal to this Court, marked as the second supplemental record on appeal in 80-7197, so that the documents will be available if the parties refer to them, and the Court accepts those refeernces as appropriate.—ED.

District Court Docket Entries

DATE	DOC. NO. [RECORD ON APPEAL]	PROCEEDINGS
6-5-80	119	[Filed] stipulation that . . . document become part of the record on appeal.
6-5-80	120	[Filed] certified [first supplemental] record on appeal [in 80-7197].
6-10-80	121 †[114]	[Filed] Order that each & every Long-Term Care Memo of Understanding entered into * * * which does not include paragraphs II, III, & IV of the partial final judg. is invalid & null, etc. Defts. are restrained from signing & entering into any Memo of Understanding concerning review of long-term care * * * Motion #114 denied, & defts.' motion for a stay pending appeal is denied . . . MOTLEY, J. m/n
6-10-80	122 †[115]	[Filed] Memo Opinion #50169 . . . Court concludes that pltffs.' motion #103 is granted, pltffs.' motion #114 is denied and defts.' motion for a stay pending appeal must be denied. So Ordered, MOTLEY, J. m/n
6-16-80	123 †[116]	[Filed] Order that the action is DISCONTINUED [; final judgment having been entered]. MOTLEY, J. m/n
7-9-80	124 †[117]	[Filed] N/A to the USCA [in 80-7559] by the defts. from the order dated 6-9-80 & entered 6-10-80. * * *
7-23-80	125 †[118]	Filed Notice of Cross Appeal [in 80-7625] by defts.-intervenors to the USCA from the order entered 6/9/80 ***

* * *

District Court Docket Entries

DATE	DOC. NO. RECORD ON APPEAL	PROCEEDINGS
10-1-80	127	[Filed] true copy of stip. from the USCA 2nd Circuit . . . that the appeal [in 80-7559] & cross appeal [in 80-7625] may be dismissed . . . Clerk USCA
		• • •
3-3-81	137	[Filed] true copy of Order from the USCA [in 80-7197] that the judgment of USDC is affirmed in part, vacated in part & modified & action is remanded to USDC for further proceedings in accordance with the opinion of this court . . . Clerk, USCA m/n
		• • •

Relevant Docket Entries in the United States Court of Appeals for the Second Circuit

Case No. 80-7197 Judge Motley Calendar Number 1234

DATE	FILINGS—PROCEEDINGS
3-12-80	Copies of district court docket entries and notice of appeal filed on behalf of Blum et ano.
	• • •
4-8-80	Record on appeal filed (original papers of district court).
	• • •
4-29-80	Appellant Blum et al brief filed, pfs (by mail).
4-29-80	Appellant Blum et al joint appendix filed, pfs (by mail).
5-7-80	Appellee Yaretsky et al brief filed, pfs.
5-20-80	Appellant Blum et al reply brief filed, pfs.
6-5-80	Appellant Blum et al motion for leave to file supplemental joint appendices filed, pfs. (Order endorsed 6-6-80 granting motions as to documents presently part of the record on appeal. Otherwise denied).
6-6-80	Appellant Blum et al supplemental joint appendix filed, pfs.
6-9-80	First supplemental record on appeal filed.
6-11-80	Case argued before: Lumbard, Mansfield, CJJ, Mehrtens, DJ.
8-25-80	Judgment affirmed in part, vacated in part and modified by published, signed opinion, Lumbard, C.J.
8-25-80	Judgment filed.
9-5-80	Appellees Yaretsky et al petition for rehearing filed, pfs.
9-8-80	Appellant Blum et al petition for rehearing filed, pfs.

Court of Appeals Docket Entries

DATE	FILINGS—PROCEEDINGS
	Appellant Blum et al petition for rehearing en banc filed, pfs.
9-24-80	Order denying appellees Yaretsky et al petition for rehearing filed.
12-8-80	Notice of filing of petition for writ of certiorari filed [by appellees]. (post card)
2-18-81	Order denying appellant Blum's petition for rehearing with suggestion for rehearing en banc filed.
2-26-81	Mandate (Opinion, Judgment) issued.
2-26-81	Certified copy of order of Supreme Court denying petition for writ of certiorari filed [by appellees].
6-26-81	Notice of filing of petition for writ of certiorari filed [by appellants]. (post card)
10-9-81	Certified copy of order from Supreme Court granting petition for writ of certiorari filed [by appellants] (S.C. #80-1952, Blum).
10-16-81	Original record on appeal received.
10-16-81	First supplement record on appeal received.
10-16-81	Second supplement record on appeal received.

First Amended Complaint

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

76 Civ 3360 (Motley)
FIRST AMENDED COMPLAINT
(Class Action)

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Plaintiffs,

—against—

PHILIP L. TOIA, individually and as Commissioner of the New York State Department of Social Services; and ROBERT A. WHALEN, M.D., individually and as Commissioner of the New York State Department of Health,

Defendants.

I. DESCRIPTION OF THE ACTION

1. This is an action by and on behalf of nursing home residents in the State of New York, eligible for or receiving Medical Assistance (Medicaid) benefits, who have been, are or will be threatened or forced to leave their nursing homes and have their Medicaid benefits reduced or terminated as a result of "Utilization Review" committee findings alleging that they are not eligible for the level of nursing home care they receive. Plaintiffs allege that, as it presently operates in nursing homes in New York State, this process of "Utilization Review" leading to involuntary transfer and reduction in Medicaid assistance is arbitrary and capricious, lacks adequate criteria, fails

to comply with legal requirements and procedural safeguards necessary for plaintiffs' protection and deprives plaintiffs of meaningful opportunity to contest proposed transfers and reductions in assistance. Plaintiffs seek declaratory and injunctive relief and damages to redress violations of rights secured to plaintiffs by Title XIX (Medicaid) of the Social Security Act, 42 U.S.C. § 1396, *et seq.*, and by the due process clause of the Fourteenth Amendment to the United States Constitution and 42 U.S.C. § 1983.

II. Jurisdiction

2. Jurisdiction is conferred upon this Court by 28 U.S.C. § 1331, and 28 U.S.C. § 1343(3) and (4). The amount in controversy, exclusive of interests and costs, exceeds $10,000. Declaratory relief is authorized by 28 U.S.C. §§ 2201 and 2202, and Rule 57 of the Federal Rules of Civil Procedure.

III. Plaintiffs

3. Plaintiff William Yaretsky is an American citizen, eighty-nine (89) years of age, residing at the American Nursing Home in New York, New York. Plaintiff Yaretsky, who has lived most of his life on the "lower east side" of Manhattan, has resided in the American Nursing Home (which is located in that neighborhood) for the past two and a half years. He is a recipient of Medical Assistance, pursuant to 42 U.S.C. § 1396, *et seq.*

4. Plaintiff Ralph Cuevas is an American citizen, seventy-seven (77) years of age, residing at the American Nursing Home in New York, New York. Plaintiff Cuevas, who has lived most of his life in the vicinity of the "lower

east side" of Manhattan, has resided in the American Nursing Home (which is located in that neighborhood) for the past seven and a half years. He is a recipient of Medical Assistance benefits, pursuant to U.S.C. § 1396, *et seq.*

5. Plaintiff GRAY PANTHERS, New York Chapter, is an unincorporated association in New York State of over 5,000 affiliated persons, having its principal office at 15 West 65 Street, New York, New York. The association includes many elderly persons who reside in nursing homes, and who are supported by Medicaid. The GRAY PANTHERS, New York Chapter, has among its objectives the development of a health care system for the elderly which provides quality health care to all persons regardless of their wealth or poverty and engages in activities to achieve this goal.

6. GRAY PANTHERS, New York Chapter, members have been injured in that they are, have been or will be involuntarily transferred or threatened with involuntary transfer from their nursing homes as a direct result of the unlawful acts and practices complained of herein.

7. As an organization, the purpose of the GRAY PANTHERS, New York Chapter, is thwarted and its operations obstructed as a direct result of the unlawful acts and practices complained of herein in that it is prevented from engaging in meaningful advocacy on behalf of its members, it is thwarted from achieving its goal of a quality health care system for the elderly regardless of their wealth or poverty, and it is impaired in its ability to engage in activities in furtherance of that goal.

IV. Defendants

8. Defendant Philip L. Toia, is the Commissioner of the New York State Department of Social Services. In that capacity, he is responsible for the administration of the entire Public Assistance program, including the Medical Assistance program, in the State of New York.

9. Defendant Robert A. Whalen, M.D., is the Commissioner of the New York State Department of Health. In that capacity, he is responsible for administration of certain aspects of the Medical Assistance program in the State of New York, and for licensing and supervising the operations of nursing homes in the state.

V. Class Action Allegations

10. The individual plaintiffs and plaintiff Gray Panthers bring this action on their own behalf and on behalf of all of those similarly situated, pursuant to Rule 23(a) and (b)(2), and of the Federal Rules of Civil Procedure. The class is composed of all persons in the State of New York who have, are or will: (a) reside in nursing homes (including "Skilled Nursing Facilities" and "Health Related Facilities"); (b) receive Medicaid assistance (42 U.S.C. § 1396, *et seq.*); and (c) be threatened or forced to leave their nursing homes and have their Medicaid benefits reduced or terminated as a result of determinations by defendants, based on "Utilization Review" committee findings alleging that plaintiffs are not eligible for the level of nursing home care they receive.

11. The class is so numerous that joinder is impracticable. Upon information and belief there are more than 1000 members of the plaintiffs' class. There are ques-

tions of law and fact which are common to the entire class. The claims of the representative plaintiffs are typical of the claims of the class. The representative plaintiffs are qualified to and will adequately protect the interests of the class. The defendants have acted or refused to act on grounds generally applicable to the class, and injunctive relief is appropriate for the class as a whole.

VI. Facts

A. *Generally*

12. Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq.*, provides federal funds to states which choose to provide medical assistance to persons unable to afford adequate medical care. A state need not participate in the Medical Assistance (Medicaid) program, but if it does so it must conform to the requirements of federal law.

13. The State of New York, through the New York State Departments of Social Services and Health and other state and local agencies, operates a Medical Assistance (Medicaid) program under which, *inter alia*, it pays the cost of care in "Skilled Nursing Facilities" and "Health Related Facilities" (referred to collectively herein as "nursing homes") for eligible persons without sufficient income or resources to pay for their own care. N.Y. Social Services Law § 364-365-a.

14. As a precondition to the receipt of federal funds for the Medicaid program, the defendants are required to file a "state plan for medical assistance" with the Secretary of Health, Education and Welfare. The plan must include a provision for periodic review of all Medicaid

patients in nursing homes to determine whether they are appropriately placed and continue to require the level of nursing home care they receive. 42 U.S.C. §§ 1396, 1396a (a)(26) and (31); 45 C.F.R. §§ 250.19, 250.23, 250.24.

15. To carry out this review, federal and state regulations require that Utilization Review committees be established for each nursing home in New York State. It is the function of these committees to evaluate the continued need of each patient for the level of nursing home care he or she receives. Patients are to be reviewed in this manner, generally every 90 days. In general, the committee are to be made up of physicians and other professionals who are not employees of, or financially interested in, the nursing home, and who are not directly responsible for the patients' care. Each Utilization Review Committee operates independently of its counterparts in other nursing homes. 45 C.F.R. §§ 250.19.(a)(3) & (4), 250.23, 250.24; 10 N.Y.C.R.R. §§ 731.11 and 741.14.

16. In a case where the Utilization Review Committee's recommendation is that the patient does not require the level of nursing home care he receives, the nursing home, attending physician, patient and next of kin are to be notified in writing of the Committee's finding. Notice of the finding is also to be given to an official under control and direction of the defendant who is responsible for making decisions regarding the patient's Medicaid eligibility and payment. 45 C.F.R. §§ 250.19.(a)(3) & (4), 250.24, 250.24 [sic]; 10 N.Y.C.R.R. §§ 731.11 and 741.14. These decisions are generally made by the Department of Social Services of the city or county where the patient resides.

17. The policy and practice of defendants (or an official or agency under their control or direction) is to

make a determination that the patient is not eligible for Medicaid payments for the level of nursing care he is receiving, simply by adopting the findings of the Utilization Review Committee.

18. The current policy and practice of the New York State Department of Health is that most nursing homes are licensed to provide only a single level of care, either as "Skilled Nursing Facilities" or as "Health Related Facilities". Thus, for most patients the practical effect of a determination by defendants that the patient is ineligible for Medicaid payments for his current level of care, is to force the patient to leave his nursing home.

19. Defendants require that their decision, based on the Utilization Review Committee findings, be implemented by the patient accepting discharge from the nursing home and transfer to a facility offering a lower level of care or to the community. If the patient refuses to be transferred, defendants require that the patient's Medicaid benefits be terminated. If the patient requests a "fair hearing" to contest defendants' determinations, Medicaid benefits are continued pending the outcome of the hearing, (45 C.F.R. § 205.10 and 18 N.Y.C.R.R. § 358) thus permitting the patient to remain at the nursing home during this period.

B. *Plaintiffs* YARETSKY *and* CUEVAS

20. Plaintiffs YARETSKY and CUEVAS are, and have been for a period of years, recipients of Medicaid which finances the costs of plaintiffs' care in the American Nursing Home, a skilled nursing facility.

21. In or about December, 1975, recommendations were made to the New York City Department of Social Services following a review of their status at the American

Nursing Home, that plaintiffs YARETSKY and CUEVAS were no longer in need of, and therefore no longer eligible for, care in a skilled nursing facility. The New York City Department of Social Services administers the Medicaid program in New York City and is under the control and direction of defendant TOIA.

22. On information and belief, an employee of the American Nursing Home requested administrative hearings for plaintiffs YARETSKY and CUEVAS, who were physically brought to the hearings which were held on February 27, 1976.

23. On March 30, 1976, defendant TOIA issued Decisions After Fair Hearings directing that plaintiffs' YARETSKY and CUEVAS Medicaid benefits be terminated unless they accepted transfer to a "health related facility" providing a reduced level of nursing home care. Therefore, the transfer is a decrease in the Medicaid benefits of plaintiffs YARETSKY and CUEVAS.

24. On June 14, 1976, plaintiffs YARETSKY and CUEVAS requested that defendant TOIA set aside the decisions and schedule a new hearing. On July 23, 1976, this request was denied.

VII. FIRST CAUSE OF ACTION

25. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 12-24.

26. The plaintiffs make (made or will make) their homes in nursing homes in New York State where they receive (received or will receive) Medicaid assistance to pay for part or all of their care. Most nursing home patients reside in their nursing homes for several or more

years and most know no other home. Many of the plaintiffs have lived in the communities in which their nursing homes are located for much of their lives.

27. Through the operation of the "utilization review" and related administrative processes described in paragraphs 14-19 above, plaintiffs were or will be determined by defendants to be ineligible to remain in their present nursing homes and are, were or will be threatened with involuntary transfer from their nursing homes and with reduction or termination of their Medicaid assistance.

28. In addition, these patients are, were or will be exposed to a phenomenon injurious to their lives, health and well-being known as "transfer trauma", as a result of being uprooted from their homes and communities.

29. The utilization and medical review process in New York for assessing plaintiff's eligibility for their level of nursing home care, and the related administrative processes by which defendants affirm, review and implement these adverse eligibility determinations, operates without adequate, appropriate or uniform standards and criteria.

30. As a result, the entire decision process and the decisions of plaintiffs' ineligibility based on Utilization and Medical Review Committee findings, are arbitrary and capricious.

31. Furthermore, plaintiffs are thereby deprived of a meaningful opportunity for administrative or judicial review of adverse determinations.

32. In particular, the needs of plaintiffs YARETSKY and CUEVAS to remain in their skilled nursing facility were not

evaluated against previously approved written criteria developed by a properly constituted Utilization Review Committee.

33. Also, with regard to plaintiffs YARETSKY and CUEVAS, defendants failed to adhere to standards set forth in Title XIX of the Social Security Act and in applicable regulations for evaluating these plaintiffs' needs to remain in their skilled nursing facility.

34. As a result of defendants' failure, defendants' determinations (described in paragraphs 21-24 above) were contrary to the health needs of plaintiffs YARETSKY and CUEVAS and to professionally recognized standards of care.

35. Defendants thus violate:

(a) 45 C.F.R. § 250.19(a)(3) and (4) in that level-of-care determinations are not evaluated against adequate written criteria;

(b) 45 C.F.R. § 250.18 in that the defendants have failed to adequately monitor and supervise the utilization review process in nursing homes and to insure its effectiveness;

(c) 42 U.S.C. § 1396a(a)(3) in that defendants deprive plaintiffs of a meaningful opportunity for review of adverse determinations of eligibility for nursing home care;

(d) 42 U.S.C. § 1396a(a)(17) in that defendants have failed to include reasonable standards for determining eligibility for and the extent of medical assistance;

(e) 42 U.S.C. § 1396a(a)(19) in that defendants have failed to provide necessary safeguards to insure

that eligibility is determined in a manner consistent with the best interests of the plaintiffs;

(f) plaintiffs' rights to due process under the Fourteenth Amendment to the United States Constitution in that the defendants' decision process, and decisions of ineligibility based on utilization review findings are arbitrary and capricious, and that plaintiffs are deprived of a meaningful opportunity for review of these decisions;

(g) 42 U.S.C. § 1983 in that, under color of law, defendants violated plaintiffs' due process and other federal rights, and/or knew or should have known about such violations but permitted or failed to prevent such violations.

VIII. Second Cause of Action

36. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 12-24.

37. Defendants permit Utilization Review Committees, whose determinations form the basis for defendants' decisions requiring plaintiffs to be transferred from their nursing homes, to operate in violation of the requirements of 45 C.F.R. §§ 250.19(a)(3) and (4), including, *inter alia*, requirements regarding: (a) the composition of committees, (b) opportunity for comment by the patient's physician, and (c) notice to plaintiffs and others of the Committees' findings.

38. In particular, the needs of plaintiffs Yaretsky and Cuevas to remain in the skilled nursing facility were not reviewed by a properly constituted Utilization Review Committee, and their attending physician was not given

an opportunity to submit his views prior to recommendations having been made regarding these plaintiffs' continued residence and care in the skilled nursing facility.

39. Defendants thus violate:

(a) 45 C.F.R. § 250.18 in that they have failed to adequately monitor and supervise the operation of these committees;

(b) 42 U.S.C. § 1396a(a)(19) in that they have failed to provide necessary safeguards to insure that eligibility is determined in a manner consistent with the best interests of plaintiffs;

(c) 42 U.S.C. § 1983 in that, under color of law, knew or should have known that plaintiffs' due process and other federal rights were violated but permitted, or failed in their duty to prevent such violations.

IX. Third Cause of Action

40. Plaintiffs repeat and reallege each and every allegation set forth in paragraphs 25-28.

41. Defendants have failed to adopt policies and procedures under which nursing homes are licensed and required to provide for multiple levels of care within each facility. Such a policy would render it generally unnecessary to involuntarily transfer a patient found to be ineligible for the level of care he or she had been receiving.

42. Defendants thus violate 42 U.S.C. § 1396a(a)(19) in that they have failed to provide necessary safeguards to insure that eligibility is determined and care provided in a manner consistent wtih simplicity of administration and the best interests of the plaintiffs.

X. Fourth Cause of Action

(Plaintiffs Yaretsky and Cuevas only)

43. The plaintiffs repeat and reallege each and every allegation set forth in paragraphs 12-24.

44. At the time of the recommendations of the New York City Department of Social Services that plaintiffs Yaretsky and Cuevas did not require skilled nursing care, defendants failed to advise plaintiffs Yaretsky and Cuevas adequately of the recommendations or of their meaning.

45. Defendants also failed to advise plaintiffs Yaretsky and Cuevas of their right to contest these recommendations in an administrative hearing, and, at such a hearing, to be represented by counsel, to present evidence in opposition to these recommendations, and to confront any evidence to be offered in support of these recommendations.

46. Defendants' failures, as alleged in paragraphs 44 and 45, are particularly egregious in light of the special circumstances connected with plaintiffs' advanced ages and decreased capabilities.

47. Although physically present at the administrative hearings held on February 27, 1976, plaintiffs Yaretsky and Cuevas were unable to participate in any meaningful way due to defendants' failures as alleged in paragraphs 44 and 45.

48. With regard to plaintiffs Yaretsky and Cuevas, defendants thus violated:

(a) 45 C.F.R. § 205.10(a) which requires such notice and opportunity for hearing;

(b) rights secured to plaintiffs Yaretsky and Cuevas by the Fourteenth Amendment to the United

States Constitution which guarantees their right to due process of law prior to a decrease in their Medicaid benefits;

(c) 42 U.S.C. § 1983 in that, under color of law, they violated the due process and other federal rights of plaintiffs YARETSKY and CUEVAS, and/or know or should have known of such violations but permitted or failed to prevent such violations.

XI. IRREPARABLE INJURY

49. Plaintiffs are severely and irreparably injured in that defendants' actions subject them to arbitrary and illegal decreases in their Medicaid benefits, changes in their pattern of medical care, and "transfer trauma". Plaintiffs have no adequate remedy at law.

XII. PRAYER

WHEREFORE, plaintiffs pray on behalf of themselves and all others similarly situated that this Court:

1. assume jurisdiction of this cause;

2. certify the class of plaintiffs pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure;

3. enter a judgment declaring that defendants have:

(a) violated plaintiffs' rights under the Due Process Clause of the Fourteenth Amendment to the United States Constitution, 42 U.S.C. § 1983, 42 U.S.C. § 1396a(a) and 45 C.F.R. § 250.18 and 19;

(b) violated plaintiffs' rights in that the recommendations, and decisions concerning plaintiffs' eligibility to

remain in their nursing homes are not in the interests of plaintiffs' health needs, or consistent with professionally recognized standards of health care;

(c) violated plaintiffs' rights by conducting an illegal, arbitrary and capricious utilization review process, and by rendering decisions in reliance on that process, in violation of applicable federal regulations and due process of law;

(d) violated the rights of plaintiffs YARETSKY and CUEVAS as set forth in 45 C.F.R. § 205.10(a);

4. enter preliminary and permanent injunctions enjoining the defendants, their agents and successors, from transferring or requiring the involuntary transfer of any members of the plaintiffs' from his or her nursing home or decreasing or terminating the Medical Assistance benefits of any member of the plaintiff class unless and until defendants comply with all of the legal requirements due to plaintiffs;

5. order the defendants to pay damages to those members of the plaintiff class, or their heirs, who are, were or will be involuntarily transferred from their nursing homes and whose Medical Assistance benefits have been decreased or terminated as a result of defendants' unlawful acts, in the amount of one million dollars ($1,000,000.00);

6. grant plaintiffs their costs and reasonable attorneys fees;

7. grant such other and further relief as may be just and proper.

DATED: New York, New York
February 9, 1977

PHILIP M. GASSEL, Esq.
Legal Services for the
Elderly Poor
2095 Broadway, Room 304
New York, NY 10023
(212) 595-1340

ELLICE FATOULLAH, Of Counsel to
NANCY E. LEBLANC, Esq
MFY Legal Services, Inc.
214 East 2nd Street
New York, NY 10009

Attorneys for Plaintiffs

Answer to Amended Complaint

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

Defendants, Philip L. Toia and Robert A. Whalen, by their attorney, LOUIS J. LEFKOWITZ, Attorney General of the State of New York, for their answer to the amended complaint herein allege as follows:

FIRST: Deny the allegations contained in paragraph "1" in so far as the allegations therein may be construed to allege that defendants violated any right of any plaintiff, or that this court has jurisdiction of the action, or that this action is authorized by 42 U.S.C. § 1983.

SECOND: Admit the allegations contained in paragraphs "3" and "4", except deny knowledge or information sufficient to form a belief as to the truth or accuracy of the statement that Yaretsky and Cuevas have lived most of their lives on the lower east side of Manhattan.

THIRD: Deny knowledge or information sufficient to form a belief as to the truth or accuracy of the statements contained in paragraph "5".

FOURTH: In reference to paragraph "8", admit that Philip L. Toia is the Commissioner of the New York State Department of Social Services and respectfully refer this Court to the appropriate published statutes and regulations

for a true and accurate statement of defendant Toia's responsibilities and duties.

FIFTH: In reference to paragraph "9", admit that Robert A. Whalen, M.D., is the Commissioner of the New York State Department of Health and respectfully refer this Court to the appropriate published statutes and regulations for a true and accurate statement of defendant Whalen's responsibilities and duties.

SIXTH: Deny the allegations contained in paragraphs "12", "13", "14", "15" and "16", and respectfully refer this Court to Title 19 of the Social Security Act, 42 U.S.C. § 1396, *et seq.* and the relevant federal and state statutes and regulations for a true and accurate description of New York's plan for medical assistance and the operation of Utilization Review Committee, and the true meaning of the statutes and regulations cited therein by plaintiffs.

SEVENTH: Admit the allegations contained in paragraph "19", except deny that defendants' decision concerning the patient's need for a certain level of care is based solely on the findings of the Utilization Review Committee and respectfully refer this Court to the statutes and regulations cited therein for the true meaning thereof, and affirmatively allege that defendants implement federal regulations and requirements.

EIGHTH: Admit the allegations contained in paragraph "20".

NINTH: Deny the allegations contained in paragaph "21", except admit that recommendations were made to the New York City Department of Social Services in December, 1975, regarding the status of plaintiffs Yaretsky and Cuevas at American Nursing Home, but refer to the

full text of said recommendations for a true and accurate statement of the contents thereof, and refer to the appropriate published statutes and regulations for an accurate statement of the relationship between the defendants and the New York City Department of Social Services.

TENTH: Deny knowledge or information to form a belief as to the truth or accuracy of the statement contained in paragraph "22", except admit that fair hearings were held for Yaretsky and Cuevas on February 27, 1976.

ELEVENTH: Deny the allegations contained in paragraph "23", except admit that fair hearing decisions were rendered on March 30, 1976 and refer this court to the full text of the fair hearing decision for a true and accurate statement of the contents thereof.

TWELFTH: Deny the allegations contained in paragraph "24", except admit that plaintiffs Yaretsky and Cuevas, by letter dated June 14, 1976, requested an official of New York State Department of Social Services to set aside the decisions and schedule new hearings, and admit that by letter dated July 23, 1976, said official denied this request.

THIRTEENTH: Deny knowledge or information sufficient to form a belief as to the truth or accuracy of the statements contained in paragraph "26".

FOURTEENTH: Deny each and every allegation contained in paragraphs "2", "6", "7", "10", "11", "17", "18", "25", "27", "28", "29", "30", "31", "32", "33", "34", "35 (a-g)", "36", "37", "38", "39 (a-c)", "40", "41", "42", "43", "44", "45", "46", "47", "48 (a-c)" and "49".

AS AND FOR A FIRST COMPLETE AND AFFIRMATIVE DEFENSE.

FIFTEENTH: This Court has no subject matter jurisdiction.

AS AND FOR A SECOND COMPLETE AND AFFIRMATIVE DEFENSE.

SIXTEENTH: This Court should abstain from this action.

AS AND FOR A THIRD COMPLETE AND AFFIRMATIVE DEFENSE.

SEVENTEENTH: This action is barred by the doctrines of waiver and estoppel.

AS AND FOR A FOURTH COMPLETE AND AFFIRMATIVE DEFENSE.

EIGHTEENTH: Defendants have violated no constitutional or statutory or other rights of the plaintiffs.

AS AND FOR A FIFTH COMPLETE AND AFFIRMATIVE DEFENSE.

NINETEENTH: The complaint fails to state a claim upon which relief can be granted.

AS AND FOR A SIXTH COMPLETE AND AFFIRMATIVE DEFENSE.

TWENTIETH: Class action status is inappropriate for this action and should be denied.

AS AND FOR A SEVENTH COMPLETE AND AFFIRMATIVE DEFENSE.

TWENTY-FIRST: Damages against the defendants are barred by the Eleventh Amendment to the United States Constitution.

AS AND FOR A EIGHTH COMPLETE AND AFFIRMATIVE DEFENSE.

TWENTY-SECOND: Defendants at all times relevant herein acted in good faith in all respects.

AS AND FOR A NINTH COMPLETE AND AFFIRMATIVE DEFENSE.

TWENTY-THIRD: The complaint fails to set forth facts sufficient for showing the violation of any constitutional right or other basis of federal jurisdiction.

WHEREFORE, defendants Toia and Whalen respectfully request that the complaint be dismissed in all respects, that defendants be awarded costs and disbursements of this action, and such other and further relief as the Court deems just and proper.

Dated: New York, New York
May 23, 1977

LOUIS J. LEFKOWITZ
Attorney General of the
State of New York
Attorney for Defendants Toia and Whalen

By s/ KEVIN MCKAY
Kevin McKay
Assistant Attorney General
Office & P.O. Address
2 World Trade Center
New York, N.Y. 10047
Tel. No. (212) 488-7410

November 30, 1977 Order to Show Cause Joining Plaintiffs-Intervenors Wolper, Shulman, Rossoff and Ashkenazy and Issuing Temporary Restraining Order

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

CIVIL ACTION
No. 76 Civ. 3360
(CBM)

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTERS, NEW YORK CHAPTER,

Plaintiffs,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, and PAULINE ASHKENAZY, on behalf of themselves, and all others similarly situated,

against

CARMEN SHANG, individually and as acting Commissioner of the New York State Department of Social Services; ROBERT P. WHALEN, M.D., individually and as Commissioner of the New York State Department of Health; and J. HENRY SMITH, individually and as Commissioner of the New York City Department of Social Services,

Defendants.

Upon the attached proposed intervenor complaint, attached affidavits, plaintiff-intervenor's supporting brief dated November 22, 1977, and all prior papers and proceedings in this action, it is

November 30, 1977 Order to Show Cause—Wolper, Shulman, Rossoff, Ashkenazy

ORDERED, that the defendants or their attorneys show cause before this Court in Room 905 in the United States Court House, Foley Square, New York, New York on the 8th day of December, 1977, at 10 o'clock in the forenoon of that day, or as soon thereafter as counsel may be heard, WHY an order should not be made granting, pending the determination of this action, a preliminary injunction, pursuant to Rule 65 of the Federal Rules of Civil Procedure, enjoining and restraining the defendants, and their successors in office, officers, servants, employees and agents, including the proprietor and manager of the Parkshore Manor health related facility, from discontinuing the eligibility of the plaintiffs-intervenors Rae Wolper, Rose Shulman, Bessie Rossoff, and Pauline Ashkenazy to remain in the health related facility in which they are patients, from failing to continue uninterrupted their full levels of Medical Assistance (Medicaid) benefits for intermediate nursing care, and from transfering said plaintiffs-intervenors from the Parkshore Manor health related facility.

ORDERED, that pursuant to Rules 24(b)(2) of the Federal Rules of Civil Procedures, Rae Wolper, Rose Shulman, Bessie Rossoff, and Pauline Ashkenazy be and hereby are permitted to intervene as plaintiffs in the above-entitled action.

ORDERED, that pursuant to Rule 21 of the Federal Rules of Civil Procedure, J. Henry Smith, individually and as Commissioner of the New York City Department of Social Services, be and hereby is joined as a party defendant in this action.

ORDERED, pursuant to Rule 65 of the Federal Rules of Civil Procedure, that pending the final determination by

this Court of the plaintiffs-intervenors' motion for a preliminary injunction, the defendants and their sucessors in office, servants, employees and agents, including the proprietor and manager of the Parkshore Manor health related facility, be and the same hereby are temporarily enjoined and restrained from discontinuing the eligibility of the plaintiffs-intervenors Rae Wolper, Rose Shulman, Bessie Rossoff, and Pauline Ashkenazy to remain in the health related facility in which they are patients from failing to continue uninterrupted their full levels of Medical Assistance (Medicaid) benefits for intermediate nursing care, and from transfering said plaintiffs-intervenors from the Parkshore Manor health related facility. Security for this application pursuant to Rule 65 is waived because of the poverty of the plaintiffs-intervenors.

Sufficient reason appearing therefore, it is FURTHER ORDERED, that personal service of a copy of this order and the papers upon which it was granted, on the Attorney General of the State of New York, Two World Trade Center, New York, New York, and on the Corporation Counsel of the City of New York, Municipal Building, New York, New York, on or before 6 o'clock pm on the 30 day of November 1977, shall constitute sufficient service of this order.

Dated: New York, New York
November 30, 1977.

s/ CONSTANCE BAKER MOTLEY
UNITED STATES DISTRICT JUDGE

December 13, 1977 Order to Show Cause Joining Plaintiffs-Intervenors Birenzweig, Zahl, Kolman, J. Lundy and P. Lundy, Certifying Class and Issuing Temporary Restraining Order for All Intervenors

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

CIVIL ACTION
No. 76 Civ. 3360
(CBM)

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTERS, NEW YORK CHAPTER,

Plaintiffs,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY, and PHILOMENA LATONE LUNDY, on behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors,

against

CARMEN SHANG, individually and as acting Commissioner of the New York State Department of Social Services; ROBERT WHALEN, M.D., individually and as Commissioner of the New York State Department of Health; and J. HENRY SMITH, individually and as Commissioner of the New York City Department of Social Services,

Defendants.

December 13, 1977 Order to Show Cause (Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy)—Class Certification—Temporary Restraining Order

Upon the proposed intervenor complaint, supporting affidavits, plaintiffs-intervenors' supporting brief, and all prior proceedings and papers in this action, it is

ORDERED, that the defendants or their attorneys show cause before this Court in Room 905 in the United States Court House, Foley Square, New York, New York, on the 20th day of December, 1977, at 2:00 p.m. in the afternoon of that day, or as soon thereafter as counsel can be heard, WHY an order should not be made, granting, pending the determination of this action, a preliminary injunction, pursuant to Rule 65 of the Federal Rules of Civil Procedure, enjoining and restraining the defendants, and their successors in office, officers, servants, employees and agents, including the proprietors and managers of skilled nursing and intermediate care facilities in New York State, from discontinuing the eligibility to remain in the facilities in which they reside, from transfering from the facilities, and from reducing and terminating the Medicaid benefits of plaintiffs-intervenors Mary Foley, Rae Wolper, Rose Shulman, Pauline Ashkenazy, Sadie Birenzweig, Martha Zahl, Edna Kolman, James Lundy, Philomena Latone Lundy, and any member of the plaintiff class as defined above [below] who receives or received determination of ineligibility to remain in the skilled nursing or intermediate care facility in which he/she resides and who does not or did not receive, following determination by the Utilization Review Committee, timely and fully adequate written notice that includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific regulations supporting the action, explanation of the individual's right to request an evidentiary state agency hearing, and the circumstances under which assistance is continued if a hearing is re-

quested, and/or does not or did not have prior to the fair hearing notice of access and a fully adequate opportunity to examine the contents of his/her files and records and all documents and records used against him/her at the hearing or relied on in making the initial determination, including medical records.

ORDERED (1), that pursuant to Rule 24(b)(2) of the Federal Rules of Civil Procedure, Sadie Birenzweig, Martha Zahl, Edna Kolman, James Lundy and Philomena Latone Lundy be and hereby are permitted to intervene as plaintiffs in the above-entitled action;

ORDERED (2), pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure, that this action is to be maintained as a class action pursuant to Rule 23(a) and Rule 23(b)(2) of the Federal Rules of Civil Procedure, the class to be defined as all persons who are residents in skilled nursing or intermediate care facilities in the State of New York and who, following utilization review recommendations and/or fair hearings, are determined by defendants to be ineligible to receive the level of care at the facilities in which they reside and to be subject to reduction or termination of their Medicaid benefits; and

ORDERED (3), pursuant to Rule 65 of the Federal Rules of Civil Procedure, that pending the final determination by this Court of the plaintiffs-intervenors' motion for a preliminary injunction, the defendants and their successors in office, servants, employees and agents, including the proprietors and managers of the respective skilled nursing and health related facilities, be and the same hereby are temporarily enjoined and restrained from discontinuing the eligibility of the plaintiffs-intervenors

December 13, 1977 Order to Show Cause (Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy)—Class Certification—Temporary Restraining Order

Mary Foley, Rae Wolper, Rose Shulman, Pauline Ashkenazy, Martha Zahl, Sadie Birenzweig, Edna Kolman, James Lundy and Philomena Latona Lundy to remain in the skilled nursing or intermediate care facilities in which they are patients, from failing to continue uninterrupted their full levels of Medical Assistance (Medicaid) benefits for skilled nursing or intermediate nursing care, and from transfering said plaintiffs-intervenors from the facilities in which they now reside. Security for this application pursuant to Rule 65 is waived because of the poverty of the plaintiffs-intervenors.

Sufficient reason appearing therefore, it is FURTHER ORDERED, that personal service of a copy of this order and the papers upon which it was granted, on the Attorney General of the State of New York, Two World Trade Center, New York, New York, and on the Corporation Counsel of the City of New York, Municipal Building, New York, New York, on or before 5 o'clock p.m. on the 14th day of December 1977, shall constitute sufficient service of this order.

Dated: New York, New York
December 13, 1977.

/s/ CONSTANCE BAKER MOTLEY
UNITED STATES DISTRICT JUDGE

Intervenor Complaint—Foley (Excerpts)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

Civil Action No. 76 Civ. 3360 (CBM)
INTERVENOR COMPLAINT—CLASS ACTION

MARY FOLEY, on behalf of herself and all others similarly situated,

Plaintiffs,

against

CARMEN SHANG, individually and as Acting Commissioner of the New York State Department of Social Services; and ROBERT P. WHALEN, M.D., individually and as Commissioner of the New York State Department of Health,

Defendants.

PRELIMINARY STATEMENT

* * *

2. By this action, the named plaintiff, on behalf of herself and all others similarly situated, seeks a judgment declaring invalid as violative of the Social Security Act, applicable federal regulations, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment defendants' policies and practices, on their face and as applied, with respect to the utilization review and fair hearing procedures for determining a patient's eligibility to remain in his/her skilled nursing facility and to continue to receive full Medical Assistance ("Medicaid") benefits for skilled nursing service.

3. By this action, the named plaintiff, on behalf of herself and all others similarly situated, seeks a preliminary and permanent injunction enjoining and restraining the defendants their successors, and their agents from determining any patient ineligible to remain in his/her skilled nursing facility, and from reducing or terminating the patient's Medicaid benefits, without full compliance with all applicable requirements of the Social Security Act, federal regulations, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment.

* * *

CLASS ACTION ALLEGATIONS

9. Plaintiff brings this action as a class action pursuant to Rule 23(a), and in addition Rule 23(b)(2) or in the alternative Rule 23(b)(1)(A) or (B) of the Federal Rules of Civil Procedure.

10. The plaintiff class is composed of all persons who are patients in skilled nursing facilities in the State of New York and receive Medicaid assistance for skilled nursing services, and who are determined by defendants to be ineligible to remain in their skilled nursing facilities and subject to the reduction or termination of their Medicaid payments.

11. This class action is properly brought pursuant to Rule 23 because (a) the class, numbering in the hundreds, is so numerous that joinder of all members is impracticable; (b) there are questions of law and fact common to the class, namely, whether the utilization review and fair hearing procedures that result in the determination that the plaintiff and plaintiff class members are ineligible to remain in their skilled nursing facilities and to receive Medicaid assistance for skilled nursing services violate

the Social Security Act, applicable federal regulations, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment; (c) the claims of the representative plaintiff are typical of the claims of the members of the class; (d) the plaintiff's attorneys have legal resources and experience adequate to protect all members of the class, and the plaintiff will fairly and adequately protect the interests of the class; (e) the defendants, in determining plaintiff and plaintiff class members ineligible to remain in their skilled nursing facilities and to continue to receive full Medicaid assistance for skilled nursing services, by way of utilization review and fair hearing procedures that are invalid under federal law and the Constitution, have acted and refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief and corresponding declaratory relief with respect to the class as a whole; and (f) the prosecution of separate actions by individual members of the class would create a risk of varying adjudications with respect to individual members of the class which might establish incompatible standards of conduct for the defendants in this action, and would create a risk of adjudications with respect to individual members of the class that would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests.

PLAINTIFF MARY FOLEY

12. Plaintiff Mary Foley is 71 years of age and has been a resident of Crown Nursing Home, a skilled nursing facility at 3457 Nostrand Avenue, Brooklyn, New York, since March 18, 1973.

13. Plaintiff suffers from cerebral arteriosclerosis with cerebral thrombosis, arteriosclerotic heart disease with atrial fibrillation, diabetes-obesity, and an enlarged heart; she is at times confused and depressed. She has right sided hemiparesis, dragging her right leg on ambulation, and has some weakness in her right arm. She has no sense of time and has both recent and past memory deficits.

14. Plaintiff requires constant supervision in her eating habits and counselling in order to lose weight, to improve her diabetic condition, and to aid her heart condition. She is on a diabetic low-salt diet. She requires assistance in bathing and dressing. She also receives the following medication: B complex, digoxin, Lassix, Tylenol, Dyrenium. She cannot be trusted to remember to take these medications on her own. She requires observation for edema and symptoms of hypoglycemis and acidosis.

15. Plaintiff requires skilled nursing supervision every day of the week.

16. Plaintiff pays $186.50 per month from her monthly Social Security check towards her nursing home care (leaving her a personal allowance of $28.50). All other nursing home costs are paid for by Medicaid assistance payments.

17. On or about April 20, 1977, Mrs. Thomas Earls, plaintiff's sister, received written notice that the Utilization Review Committee of Crown Nursing Home had found Ms. Foley "not in need of skilled nursing care" and recommended her to a "Health Related Facility," which provides a lower level of care. (Notice attached hereto as Exhibit 1).

18. On or about April 27, 1977, Miss Shiela Earls, plaintiff's niece, wrote to the State Department of Social Services, Fair Hearing Section, and requested a fair hearing to contest the utilization review finding.

19. Neither plaintiff nor her representative Miss Earls received any documents or notice of access to documents prior to the fair hearing.

20. A Hearing was held on October 7, 1977 at the nursing home before Bernard Rostanski, Hearing Officer. At the hearing, the City Department of Social Services introduced form DMS-1, dated 4/13/77, used by the Utilization Review Committee in making its finding in Ms. Foley's case. (Form attached hereto as Exhibit 2). No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need skilled nursing care was presented.

21. Upon information and belief, the Utilization Review Committee, in making the adverse determination on the DMS-1 form, had looked only at patient's medical records and never saw or spoke to plaintiff. Upon information and belief, plaintiff's own physician, Dr. Jayamanue, had been informed of the Utilization Review recommendation, but had not signed or approved it.

22. The DMS-1 form introduced at the fair hearing to sustain the determination that Ms. Foley no longer needed skilled nursing care does not support the recommendation of the Utilization Review Committee of "Placement HRF."

23. At the fair hearing, plaintiff, by her representative Miss Earls, presented evidence of her medical condition

as stated in paragraphs 13-14, *supra*. She further introduced medical records, including nurses reports, progress notes, podiatrists notes, laboratory tests, social workers' statements and dietary notes showing plaintiff's medical condition and her continuing need for skilled nursing care. Plaintiff further showed that the trauma of transfer to a different facility would be detrimental to her health and life.

24. Mrs. Baker, a registered nurse at the home, testified at the hearing that plaintiff needed skilled nursing care and confirmed all of plaintiff's medical evidence.

25. The Hearing Officer stated at the hearing that there was no evidence of an improved condition and he would not recommend that plaintiff be moved at this time.

26. At the hearing, plaintiff's representative asked to see previous DMS-1s in the record in order to show no improvement in plaintiff's condition. Her request was denied.

27. On or about November 2, 1977, plaintiff received a Decision After Fair Hearing dated October 31, 1977 and signed by Carmen Shang, Acting Commissioner of, and Peter Mullany, Assistant Counsel to, the New York State Department of Social Services. (Decision attached hereto as Exhibit 3). That Decision affirmed the determination of plaintiff's ineligibility to remain at the skilled nursing facility. On its face, that Decision indicates that consideration was given only to the finding of the Utilization Review Committee and to only that portion of plaintiff's evidence which indicated that she needed nursing home supervision to keep from breaking her diet.

28. Neither the Hearing Officer nor the Decision of the Commissioner considered all of the medical evidence. Neither the Hearing Officer nor the Decision of the Comissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

29. Plaintiff is in immediate danger of being transferred out of the skilled nursing facility in which she now resides.

30. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the skilled nursing facility in which she resides, the plaintiff Ms. Foley has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma.

DEFENDANTS

31. Defendant Carmen Shang is the Acting Commissioner of the New York State Department of Social Services, and in that capacity he is responsible for the administration of the entire Public Assistance Program, including the Medical Assistance ("Medicaid") program, in the State of New York. He has an office at Two World Trade Center, New York, New York.

* * *

Dated: New York, New York
November 22, 1977.

Yours & etc.

KALMAN FINKEL
Attorney-in-Charge
The Legal Aid Society
Civil Division

JOHN E. KIRKLIN
Director of Litigation

SUSAN SEEL, *of Counsel*
The Legal Aid Society
Civil Appeals & Law Reform Unit
11 Park Place, 8th Floor
New York, New York 10007
212-227-2755/962-4119

JOAN MANGONES
DAVID GOLDFARB, *of Counsel*
The Legal Aid Society
Staten Island Neighborhood Office
42 Richmond Terrace
Staten Island, New York 10301
212-273-6677

Attorneys for Plaintiffs

Inervenor Complaint—Wolper, Shulman, Rossoff, Ashkenazy (Excerpts)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

CIVIL ACTION
No. 76 Civ. 3360
(CBM)

RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, and PAULINE ASHKENAZY,

Plaintiffs-Intervenors,

against

CARMEN SHANG, individually and as Acting Commissioner of the New York State Department of Social Services; ROBERT P. WHALEN, M.D., individually and as Commissioner of the New York State Department of Health; and J. HENRY SMITH, individually and as Commissioner of the New York City Department of Social Services,

Defendants.

PRELIMINARY STATEMENT

* * *

2. By this action, the named plaintiffs, on behalf of themselves and all others similarly situated, seek a judgment declaring invalid as violative of the Social Security Act, applicable federal regulations, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment defendants' policies and practices, on their face and as applied, with respect to the utilization review and fair

hearing procedures for determining a patient's eligibility to remain in his/her intermediate care facility (denominated health-related facility in New York Law) and to continue to receive full Medical Assistance ("Medicaid") benefits for intermediate care.

3. By this action, the named plaintiffs, on behalf of themselves and all others similarly situated, seek a preliminary and permanent injunction enjoining and restraining the defendants, their successors, and their agents from determining any patient ineligible to remain in his/her intermediate care facility, and from reducing or terminating the patient's Medicaid benefits, without full compliance with all applicable requirements of the Social Security Act, federal regulations, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment.

* * *

CLASS ACTION ALLEGATIONS

9. Plaintiffs bring this action as a class action pursuant to Rule 23(a), and in addition Rule 23(b)(2) or in the alternative Rule 23(b)(1)(A) or (B) of the Federal Rules of Civil Procedure.

10. The plaintiff class is composed of all persons who are patients in intermediate care facilities in the State of New York and receive Medicaid assistance for these services, and who are determined by defendants to be ineligible to remain in their facilities and subject to the reduction or termination of their Medicaid payments.

11. This class action is properly brought pursuant to Rule 23 because (a) the class, numbering in the hundreds, is so numerous that joinder of all members is impossible;

(b) there are questions of law and fact common to the class, namely, whether the utilization review and fair hearing procedures that result in the determination that the plaintiffs and plaintiff class members are ineligible to remain in their intermediate care facilities and to receive Medicaid assistance for these services violate the Social Security Act, applicable federal regulations, and the Due Process and Equal Protection Clauses of the Fourteenth Amendment; (c) the claims of the representative plaintiffs are typical of the claims of the members of the class; (d) the plaintiffs' attorneys have legal resources and experience adequate to protect all members of the class, and the plaintiffs will fairly and adequately protect the interests of the class; (e) the defendants, in determining plaintiffs and plaintiff class members ineligible to remain in their intermediate care facilities and to continue to receive full Medicaid assistance for these services, by way of utilization review and fair hearing procedures that are invalid under federal law and the Constitution, have acted and refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief and corresponding declaratory relief with respect to the class as a whole; and (f) the prosecution of separate actions by individual members of the class would create a risk of varying adjudications with respect to individual members of the class which might establish incompatible standards of conduct for the defendants in this action, and would create a risk of adjudications with respect to individual members of the class that would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests.

Intervenor Complaint—Wolper, Shulman, Rossoff, Ashkenazy

PLAINTIFFS

PLAINTIFF WOLPER

12. Plaintiff Rae Wolper is 72 years of age and has been a resident of Parkshore Manor, a Health Related Facility at 1555 Rockaway Parkway, Brooklyn, New York, since February 17, 1976.

13. Plaintiff suffers from hypertension, enlarged heart, occasional angina, arthritis and poor hearing. At times she is confused and forgetful.

14. Plaintiff requires constant supervision in taking medication and in maintaining a low salt diet. Plaintiff's electrolyte levels require periodic monitoring as does her heart condition. Her blood pressure is checked every other day and weight is checked weekly. She receives physical therapy twice per week for her arthritic knees. She also receives the following medication: Lasix, aldomet, and potassium hydrochloride (KCL). Supervision is required in administering these medications since plaintiff does not always remember to take them.

15. Plaintiff requires nursing and therapeutic care every day of the week.

16. Plaintiff pays $157.50 per month from her monthly Social Security check towards her health care (leaving her a personal allowance of $28.50). All other health care costs are paid for by Medical Assistance payments (Medicaid).

17. On or about June 25, 1977, Miss Barbara Nathanson, a social worker at Parkshore Manor, verbally informed plaintiff that she was recommended for transfer and that

she could request a fair hearing. No written notice was received.

18. On or about July 6, 1977, Miss Barbara Nathanson requested a fair hearing for the plaintiff from the State Department of Social Services, Fair Hearing Section.

19. Neither plaintiff nor her representative received any documents or notice of access to documents prior to the fair hearing except for the DMS-1.

20. A hearing was held on October 24, 1977 at the Health Related Facility before Bernard Rostanski, Hearing Officer. At the hearing, the City Department of Social Services was not present. Form DMS-1 was introduced as evidence. No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

21. Upon information and belief, the Utilization Review Committee, in making the determination on the DMS-1, had looked only at patient's medical records and never saw or spoke to plaintiff. Upon information and belief, plaintiff's physician, Dr. Zodiatis, had been informed of the Utilization Review recommendation, and appealed the decision, presenting his case for disapproval.

22. The DMS-1 form introduced at the fair hearing to sustain the determination on its face and in particular on question 9 a, b, and c does not support the recommendation of the Utilization Review Committee of "Transfer to HFA" (Adult Home).

23. At the fair hearing, plaintiff, by her representative, Bea Oaks, presented evidence of her medical condition as

stated in paragraphs 13-14, *supra*. She further testified that the trauma of transfer to a different facility would be detrimental to her health and life.

24. Shahed Ahmed, M.D., plaintiff's private doctor, wrote a letter which was presented at the hearing, recommending that the present level of health care be maintained since it is needed to control her medical conditions.

25. The representative at the hearing asked to see previous DMS-1s as well as the medical record to show no change in plaintiff's condition. Her request was denied.

26. On or about November 19, 1977, plaintiff received a Decision After Fair Hearing dated November 17, 1977, and signed by Carmen Shang, Acting Commissioner, and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of plaintiff's ineligibility to remain at the Health Related facility. On its face, that Decision indicates that consideration was given only to the finding of the Utilization Review Committee and states merely that Plaintiff failed to present sufficient medical evidence.

27. Neither the Hearing Officer nor the decision of the Commissioner considered all of the medical evidence. Neither the hearing officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the findings of the Utilization Review Committee.

28. Plaintiff is in immediate danger of being transferred out of the health related facility in which she now resides. The Adult Home to which she will be transferred receives

no Medicaid Reimbursement and as a matter of law can provide no nursing or other health related care.

29. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the health related facility in which she resides, the plaintiff, Ms. Wolper has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma.

PLAINTIFF SHULMAN

30. Plaintiff Rose Shulman is 75 years of age and since March 20, 1975 has been a resident of Parkshore Manor, a Health Related Facility located at 1555 Rockaway Parkway, Brooklyn, New York.

31. Plaintiff suffers from diabetes mellitus, dropped bladder, peptic ulcer, cysticele syricope, and heart problems and has heart pain, shortness of breath, dizziness and fainting spells. Last year plaintiff had a heart attack which kept her in the hospital for thirteen days. She had a spinal operation seven years ago and also cannot see well with her right eye.

32. Plaintiff requires supervision in her eating habits and to deal with her heart condition. She is on a diabetic low salt diet. She also receives various medication, including digoxin, diabenese, lasix, pencogasic, vasodilian, valium and tylenol. Plaintiff cannot always remember to take these medications on her own.

33. Plaintiff requires observation to have her urine checked daily, to have regular blood tests, and have her blood pressure monitored. She also requires observation because of her dizzy spells; she has fallen twice in the past

several weeks and had to be helped to her room. She requires health related facility care every day of the week.

34. Plaintiff pays $136.50 per month from her monthly Social Security check toward her health related care (leaving her a personal allowance of $28.50). All other health related care costs are paid for by Medicaid benefits.

35. On or about July 29, 1977 a Utilization Review Committee recommendation was made that plaintiff be transferred out of the Health Related Facility in which she resides to an adult home (HFA). An adult home receives no Medicaid reimbursement benefits and as a matter of law can provide no nursing or other health related care. Plaintiff was verbally informed of this recommendation to transfer her. She received no written notice.

36. Upon information and belief, the Utilization Review Committee, in making the transfer recommendation, looked only at plaintiff's medical records and never saw or spoke to her. Her physician, Dr. Zodiatis, did not approve the Utilization Review recommendation. According to the DMS-1 form on which the Utilization Review recommendation was made, the doctor's appeal was overturned because plaintiff supposedly did not have any fainting spells for over one year; that is not true (see above).

37. Plaintiff's daughter Gertrude Resnick requested a fair hearing to review the transfer recommendation of the Utilization Review Committee.

38. Prior to the fair hearing neither plaintiff nor her representative received any notice, written or oral, of

the specific criteria and reasons for the transfer determination other than the DMS-1 form, and neither plaintiff nor her representative received or was given any opportunity to examine the contents of her case file or any documents or records, other than the DMS-1, which were relevant to the issues at the hearing.

39. A fair hearing was held on October 25, 1977 at the health related facility before Bernard Rostanski, Hearing Officer. No representative from the City Department of Social Services was present. The only evidence introduced to show that plaintiff did not continue to need health related facility care was the DMS-1 form. The recommendation contained on the DMS-1 was defective (see paragraph 36, above) and plaintiff's representative, Miss Oaks, challenged it as not complying with federal regulations and standards. In addition, on its face the DMS-1 supports plaintiff's continuing need for health related facility care and the impropriety of transfer, since the registered nurse who answered questions 8 and 9 indicated that "the written orders of the attending physician and plan of care document that the [current level of] nursing and therapy are necessary," that plaintiff should not "be considered for another level of care," that "as a practical matter" she could not "be cared for as an outpatient" and that "as a practical matter" she could not "be cared for under home care."

40. Plaintiff's representative further presented evidences of her medical condition and her continuing need for health related facility care, as set forth above. Her daughter Gertrude Resnick and a friend Lily Morris also testified and confirmed plaintiff's condition. Plaintiff had earlier been transferred to the facility in which she now resides in order to be close to her daughter. Her repre-

sentative also argued that the recommended transfer should not be made because of "transfer trauma," the probable harm to plaintiff's physical and mental health caused by transfer.

41. At the hearing plaintiff's representative also asked to see her medical records; the request was denied. On information and belief, plaintiff's doctor had written in those records that she should not be transferred.

42. In mid-November, 1977 plaintiff received a "Decision after Fair Hearing" signed by defendant Carmen Shang and dated November 17, 1977, which affirmed the determination of the City Department of Social Services, found her ineligible to remain in the health related facility, and directed that she be transferred to an adult home. As is apparent on the face of the fair hearing decision, the Commissioner of Social Services simply adopted the erroneous Utilization Review determination and disregarded all the evidence presented on plaintiff's behalf at the hearing demonstrating that she continues to require health related facility care.

43. In rendering the fair hearing decision, the Commissioner failed to establish, apply and set forth criteria and safeguards to assure that the determination was made in a manner consistent with plaintiff's best interests and her total medical and psychosocial needs.

44. As a result of the adverse determination of the Commissioner, plaintiff has been found ineligible to remain in the health related facility in which she is a patient and whose servces she requires, and she will lose her Medicaid benefits for such services. The proprietor of the facility in which plaintiff resides plans on December 1, 1977 to

transfer plaintiff to an adult home where she will receive no nursing or other health related care.

45. Because of the actions of the defendants and the threat of transfer plaintiff has suffered and continues to suffer extreme mental and emotional distress and great hardship and humiliation, all of which causes her physical and mental health to further deteriorate.

PLAINTIFF ROSSOFF

46. Plaintiff Bessie Rossoff is 77 years of age and has been a resident of Parkshore Manor, a Health Related Facility at 1555 Rockaway Parkway, Brooklyn, New York since December 23, 1974. She lives there with her husband David Rossoff who is also in need of Health Related Care.

47. Plaintiff suffers from angina pectora, coronary insufficiency, hypertension, numbness of the left arm from fingers to elbow, and anxiety. She has had heart attacks in the past which have confined her to bed for a number of days.

48. Plaintiff requires constant supervision in administering her medication, maintaining a special low sodium diet, and to aid her heart condition. She requires assistance in bathing and dressing. She also receives four different medications, one of which is Valium. Plaintiff doesn't always know which medication she is supposed to take and at what particular time of day.

49. Plaintiff requires observation and monitoring of her blood pressure, periodic electrocardiogram testing and electrolyte testing.

50. Plaintiff requires nursing and other health related supervision every day of the week.

51. Plaintiff pays Parkshore Manor towards her health care from her monthly Social Security check (leaving her a personal allowance of $28.50). All other health facility costs are paid for by Medicaid.

52. Plaintiff never received any written notice that the Utilization Review Committee (URC) had recommended that she be transferred to an adult home, nor did her representative.

53. On or about May 23, 1977 plaintiff's son Edward Rossoff was given verbal notice of the URC's recommendation and on June 3, 1977 he requested a fair hearing for her.

54. Neither plaintiff nor her representative received any documents or notice of access to documents prior to the fair hearing, except for the DMS-1 Form.

55. A hearing was held on October 24, 1977 before Bernard Rostanski, State Department of Social Services Hearing Officer, at the Park Shore Manor. No representative from the City Dep't. of Social Services was present. The DMS-1 was introduced as evidence. No evidence of a determination by the City Dep't. of Social Services was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

56. On information and belief the URC in making the determination on the DMS-1 form had looked only at plaintiff's medical records and never saw or spoke to her. On information and belief, plaintiff's own physician, Dr. Antoniou, believed that a transfer would not be in her best

interests and appealed the determination of the URC and did not sign the DMS-1 form.

57. The DMS-1 form introduced to sustain the determination on its face and in particular on question 8, 9.a., b., and c., does not support the recommendation of the URC of "Placement Transfer To Adult Home."

58. Plaintiff and her son, Edward Rossoff, testified at the hearing as to her medical condition as stated above.

59. Plaintiff's representative at the hearing, Bea Oaks, asked to see her medical records and previous DMS-1s to show no change in her condition. Her request was denied.

60. On or about November 20, 1977, plaintiff received a Decision After Fair Hearing dated November 18, 1977 and signed by Carmen Shang, Acting Commissioner and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That decision affirmed the determination of the agency. That decision considered only the decision of the URC.

61. Neither the Hearing Officer nor the decision of the Commissioner considered all of the medical evidence. Neither the hearing officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the URC. As to the problem of plaintiff's separation from her husband, the Decision stated that the URC should reevaluate her husband to determine if he can be transferred also.

62. Plaintiff is in immediate danger of being transferred out of the Health Related Facility in which she

now resides. Unless Medicaid payments are ordered to be continued, the Facility threatens to transfer her against her will on December 1, 1977. The Adult Home to which she will be transferred receives no Medicaid Reimbursement and as a matter of law can provide no nursing or other health related care.

63. Because of the adverse determination of the Utilization Committee and the Commissioner, and the resulting threat of transfer out of the health related facility in which plaintiff resides, she has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma.

PLAINTIFF ASHKENAZY

64. Plaintiff Pauline Ashkenazy is 79 years of age and has been a resident of Parkshore Manor, a Health Related Facility, 1555 Rockaway Parkway, Brooklyn, New York since November 25, 1974.

65. Plaintiff suffers from a heart condition, heart palpitations, rapid pulse, high blood pressure, swollen feet, head and shoulder pains, doudenal ulcers; she is depressed at times and suffers from lack of appetite.

66. Plaintiff requires constant supervision to take the following medication: Mylonta, Probathine, Glutofal, Lafronil, Periactin Syrup, alcloctone, Digoxin, and Lasix. She is on a low salt diet. She cannot remember to take all these medications.

67. Plaintiff requires to have her pulse taken daily before the administration of digoxin.

68. Plaintiff requires nursing supervision and health related care every day of the week.

Intervenor Complaint—Wolper, Shulman, Rossoff, Ashkenazy

69. Except for a contribution from plaintiff's Social Security check, all her health care costs are paid by Medicaid.

70. On or about July or August 1977 plaintiff was verbally informed that she could no longer remain at the Health Related facility.

71. On or about August 16, 1977, the social worker for the Facility requested a fair hearing with the State Department of Social Services.

72. Neither plaintiff nor her representative received any documents or notice of access to documents prior to the fair hearing, except for a copy of the DMS-1 form.

73. A hearing was held on October 24, 1977 at the Health Related Facility before Bernard Rostanski, Hearing Officer. At the hearing, the City Department of Social Services was not present. Form DMS-1 dated July 22, 1977 was introduced in evidence. No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

74. Upon information and belief, the Utilization Review Committee, in making the determination on the DMS-1, had looked only at plaintiff's medical records and never saw or spoke to her.

75. The DMS-1 form introduced at the fair hearing to sustain the determination, on its face and in particular on questions 3E and 8 does not support the recommendation of the Utilization Review Committee of "Transfer To Adult Home."

Intervenor Complaint—Wolper, Shulman, Rossoff, Ashkenazy

76. At the fair hearing, plaintiff's representative, Bea Oaks, presented evidence of her medical condition as stated above. She further argued that the trauma of transfer to a different facility would be detrimental to plaintiff's health and life. Plaintiff testified as to her condition.

77. Plaintiff requested at the hearing through her representative to have her medical records and the prior DMS-1 forms made available. They were not made available to her.

78. On or about November 20, 1977, plaintiff received a Decision After Fair Hearing dated November 17, 1977, and signed by Carmen Shang, Acting Commissioner, and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of ineligibility to remain at the Health Related Facility. On its face, that Decision indicates that consideration was given only to the finding of the Utilization Review Committee and states merely that plaintiff presented no medical evidence.

79. Neither the Hearing Officer nor the decision of the Commissioner considered all of the medical evidence. Neither the Hearing Officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

80. Plaintiff is in immediate danger of being transferred out of the Health Related Facility in which she now resides. Unless Medicaid Payments are ordered to be continued, the Facility threatens to transfer her against

her will on December 1, 1977. The Adult Home to which she will be transferred receives no Medicaid Reimbursement and as a matter of law can provide no nursing or other health related care.

81. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the health related facility in which plaintiff resides, she has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma.

82. This transfer might harm plaintiff beyond repair by worsening her medical condition and even possibly resulting in her death.

* * *

DEFENDANTS

* * *

87. Defendant J. Henry Smith is the Commissioner of the New York City Department of Social Services, and in that capacity is responsible for the administration of the Medical Assistance ("Medicaid") program in the City of New York. The New York City Department of Social Services makes a determination finding a patient ineligible for continuing care at a particular nursing facility and it is that determination which is reviewed at the State fair hearing. Defendant Smith's office is at 250 Church Street, New York, New York.

STATUTORY AND REGULATORY SCHEME

* * *

92. 42 U.S.C. § 1396b(g)(1) requires that a state have in operation an effective program of control over utilization of skilled nursing and intermediate care services.

93. Federal regulations require that the state agency administering the Medicaid program establish and implement a state-wide utilization control program including a continuous program of review of the utilization of and need for intermediate care services for which Medicaid payment is claimed. 45 C.F.R. § 250.18.

94. The requirements of the utilization review plan required of each Intermediate Care Facility are set forth in 45 C.F.R. § 250.19(a)(4).

95. In general, utilization review committees are to be established in each intermediate care home to evaluate the continued need of each patient for ICF care every 6 months. The definition of need for intermediate care is codified at 45 C.F.R. § 249.10(a)(15). Committees are made up of physicians and professionals who are not employees or financially interested in the nursing home and not directly responsible for the patients' care. 45 C.F.R. §§ 250.19(a) (4). Also 10 N.Y.C.R.R. § 741.14.

96. If the Utilization Review Committee recommends that the patient does not require intermediate care, the nursing home, attending physician, patient and next of kin are to be notified in writing of the finding. Notice is also to be given to an official under the control and direction of the state agency who is responsible for making decisions regarding the patient's Medicaid eligibility and payment. 45 C.F.R. §§ 250.19(a)(4).

• • •

98. The State is required to establish and insure compliance with standards, methods, and safeguards to assure that intermediate care services are given to those who need them and that eligibility for such services is determined in a manner consistent with the best interests of the patients. 42 U.S.C. §§ 1396a(a)(17), (a)(19), (a)(22) (D); 1396b(g)(1)(D). 45 C.F.R. § 250.24.

* * *

101. The State is required to insure that a patient is not transferred from a nursing home without consulting with the patient, and unless for medical reasons. 45 C.F.R. § 249.12.

102. The New York City Department of Social Services purportedly renders, following the Utilization Review Committee's recommendation, a determination that a patient is not eligible to continue to receive the level of care he/she is receiving at the facility where he/she resides. That determination is subject to fair hearing review by the State Department of Social Services.

* * *

Dated: New York, New York
November 30, 1977

Yours & etc.,

[Attorneys' subscriptions and office addresses omitted in printing.]

Attorneys for Plaintiffs-Intervenors

Intervenor Complaint—Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy (Excerpts)

UNITED STATE DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

CIVIL ACTION
No. 76 Civ. 3360
(CBM)

INTERVENOR COMPLAINT—CLASS ACTION

SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY, and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Plaintiffs,

against

CARMEN SHANG, individually and as Acting Commissioner of the New York State Department of Social Services; ROBERT P. WHALEN, M.D., individually and as Commissioner of the New York State Department of Health; and J. HENRY SMITH, individually and as Commissioner of the New York City Department of Social Services,

Defendants.

PRELIMINARY STATEMENT

• • •

3. By this action, the named plaintiffs, on behalf of themselves and all others similarly situated, seek a preliminary and permanent injunction enjoining and restraining the defendants, their successors, and their agents from

determining any patient ineligible to remain in his/her skilled nursing or intermediate care facility, and from reducing or terminating the patient's Medicaid benefits, without full compliance with all applicable requirements of the Social Security Act, federal regulations, New York State Administrative Procedure Act and the Due Process and Equal Protection Clauses of the Fourteenth Amendment.

* * *

CLASS ACTION ALLEGATIONS

9. Plaintiffs bring this action as a class action pursuant to Rule 23(a), and in addition Rule 23(b)(2) or in the alternative Rule 23(b)(1)(A) or (B) of the Federal Rules of Civil Procedure.

10. The plaintiff class is composed of all persons who are patients in skilled nursing or intermediate care facilities in the State of New York and receive Medicaid assistance for these services, and who are determined by defendants to be ineligible to remain in their facilities and subject to the reduction or termination of their Medicaid payments.

11. This class action is properly brought pursuant to Rule 23 because (a) the class, numbering in the hundreds, is so numerous that joinder of all members is impossible; (b) there are questions of law and fact common to the class, namely, whether the utilization review and fair hearing procedures that result in the determination that the plaintiffs and plaintiff class members are ineligible to remain in their skilled nursing or intermediate care facilities and to receive Medicaid assistance for these services violate the Social Security Act, applicable federal regulations, New York State Administrative Procedure Act and

the Due Process and Equal Protection Clauses of the Fourteenth Amendment; (c) the claims of the representative plaintiffs are typical of the claims of the members of the class; (d) the plaintiffs' attorneys have legal resources and experience adequate to protect all members of the class, and the plaintiffs will fairly and adequately protect the interests of the class; (e) the defendants, in determining plaintiffs and plaintiff class members ineligible to remain in their skilled nursing or intermediate care facilities and to continue to receive full Medicaid assistance for these services, by way of utilization review and fair hearing procedures that are invalid under federal and state law and the Constitution, have acted and refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief and corresponding declaratory relief with respect to the class as a whole; and (f) the prosecution of separate actions by individual members of the class would create a risk of varying adjudications with respect to individual members of the class which might establish incompatible standards of conduct for the defendants in this action, and would create a risk of adjudications with respect to individual members of the class that would as a practical matter be dispositive of the interests of the other members not parties to the adjudications or substantially impair or impede their ability to protect their interests.

Plaintiffs

Plaintiff Sadie Birenzweig

12. Plaintiff Sadie Birenzweig, is 93 years of age and has been a resident of Sheepshead Nursing Home, a skilled nursing facility at 2840 Knapp Street, Brooklyn, New York for about one (1) year.

Intervenor Complaint—Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy

13. Plaintiff had two strokes, has severe cataracts in her eyes, is hard of hearing, walks with a walker, has arteriosclerosis heart disease, high blood pressure, arthritis and memory deficits.

14. Plaintiff requires constant supervision in taking medication and maintaining a salt-free diet. She needs assistance in dressing and bathing.

15. Plaintiff requires observation for problems with her feet, and a chronic infection problem with her finger.

16. Plaintiff requires skilled nursing and therapeutic care every day of the week.

17. Plaintiff pays the nursing home every month from her monthly Social Security check (leaving her a personal allowance of $28.50). All other health care costs are paid for by Medical Assistance payments (Medicaid).

18. On or about July 1977 a social worker at the nursing home verbally informed plaintiff's daughter Marion Kopelowitz, that plaintiff was recommended for transfer from the home and that she could request a fair hearing. Plaintiff received no written or oral notice of any kind.

19. On or about July 27, 1977, plaintiff's daughter, requested a fair hearing from the State Department of Social Services, Fair Hearing Section.

20. Neither plaintiff nor her representative received any documents whatsoever, or notice of access to documents prior to the fair hearing.

21. A hearing was held on October 24, 1977 at the Nursing Home before Bernard Rostanski, State Hearing Officer.

On information and belief, at the hearing, the City Department of Social Services was not present. Plaintiff's son and daughter were present at the hearing. Plaintiff's son, Leon Burns, asked if plaintiff should come into the hearing room. The hearing officer said it was not necessary. Plaintiff was not present for the hearing. No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

22. The Utilization Review Committee, in making the determination on the DMS-1, had looked only at plaintiff's medical records and never saw or spoke to plaintiff.

23. At the fair hearing, plaintiff's son and daughter presented evidence of her medical condition as stated in paragraphs 13-16 *supra*. They further argued that the trauma of transfer to a different facility would be detrimental to plaintiff's health and life. They were given absolutely no information at the hearing. They did not even see the DMS-1 form upon which the decision was allegedly based. They were not shown plaintiff's medical records. They were not told the basis for the decision.

24. On or about November 21, 1977 plaintiff received a Decision After Fair Hearing dated November 17, 1977 and signed by Carmen Shang, Acting Commissioner and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of plaintiff's ineligibility to remain at the skilled nursing facility. On its face, that Decision indicates that consideration was given only to the finding of the Utilizatoni Review Committee and states merely that plaintiff

presented no medical evidence. The decision states plaintiff appeared at the hearing, which is not true.

25. Neither the Hearing Officer nor the decision of the Commissioner considered all of the medical evidence. Neither the Hearing Officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

26. Plaintiff is in immediate danger of being transferred out of the skilled nursing facility in which she now resides. Unless Medicaid payments are ordered to be continued, the Facility threatens to transfer her against her will very shortly. The Health Related Facility to which she will be transferred provides no skilled nursing care which she requires. That Facility is further from plaintiff's family whose visits she depends on for her mental well-being. Because of plaintiff's advanced age and condition this transfer could seriously set back her health and be detrimental to her safety and life.

27. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the skilled nursing facility in which plaintiff resides, plaintiff has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma. This transfer might harm plaintiff beyond repair by worsening her medical condition and even possibly resulting in her death.

PLAINTIFF MARTHA ZAHL

28. Martha Zahl is 87 years of age and has been a resident of Sheepshead Nursing Home, a skilled nursing

facility at 2840 Knapp Street, Brooklyn, New York since July 28, 1972.

29. Plaintiff suffers from high blood pressure, hypertension, osteoarthritis, cerebral ischemia, osteoporotuis.

30. Plaintiff requires constant supervision in taking medication and in bathing and dressing, taking of blood pressure before Digoxin is administered, therapy for her legs, hot water pads, podiatrist supervision. Plaintiff also receives the following medication: Lasix, Digoxin, Aldomet, K-Lyte, Nitroglycerine.

31. Plaintiff requires nursing and therapeutic care every day of the week.

32. Plaintiff pays $116 per month from her monthly Social Security check towards her health care (leaving her a personal allowance of $28.50). All other health care costs are paid for by Medical Assistance payments (Medicaid).

33. On or about July 1977, written notice was sent to plaintiff's daughter, Miriam Tessler, stating that plaintiff was recommended for transfer to a Health Related Facility and that she could request a fair hearing. Plaintiff received no written notice of any kind.

34. On or about July 1977, plaintiff's son Solomon Zahl requested a fair hearing from the State Department of Social Services, Fair Hearing Section.

35. Neither plaintiff nor her representative received any documents or notice of access to documents prior to the fair hearing.

Intervenor Complaint—Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy

36. A hearing was held on October 24, 1977 at the skilled nursing facility before Bernard Rostanski, State Hearing Officer. At the hearing, the City Department of Social Services was not present. Plaintiff was not shown the DMS-1 form which is claimed was introduced as evidence. No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

37. Upon information and belief, the Utilization Review Committee, in making the determination on the DMS-1, had looked only at plaintiff's medical records and never saw or spoke to plaintiff. The DMS-1 form incorrectly fails to note that: Plaintiff cannot walk without assistance (ques. 4); plaintiff uses a wheelchair; for bathing, plaintiff needs total help (ques. 4); for dressing, plaintiff needs total help (ques. 4); and plaintiff's hearing is impaired (ques. 6).

38. The DSM-1 form allegedly introduced at the fair hearing to sustain the determination on its face and in particular on question 3f, 3e and 8 does not support the recommendation of the Utilization Review Committee of "Placement HRF".

39. At the fair hearing, plaintiff's son, Solomon Zahl, did not know and was not informed he could present medical evidence at the hearing. Neither he nor plaintiff was given access to plaintiff's medical records. Neither he nor plaintiff was informed of the basis for the initial decision or the standard, if any, for reviewing it.

40. On or about November 25, 1977, plaintiff received a Decision After Fair Hearing dated October 24, 1977, and

signed by Carmen Shang, Acting Commissioner and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of plaintiff's ineligibility to remain at the skilled nursing facility. On its fact, that Decision indicates that consideration was given only to the finding of the Utilization Review Committee and states merely that plaintiff presented no medical evidence.

41. Neither the Hearing Officer nor the Decision of the Commissioner considered all of the medical evidence. Neither the Hearing Officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

42. Plaintiff is in immediate danger of being transferred out of the skilled nursing facility in which she now resides. Unless Medicaid payments are ordered to be continued, the Facility threatens to transfer her against her will.

43. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the skilled nursing facility in which plaintiff resides, she has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma. This transfer might harm plaintiff beyond repair by worsening her medical condition and even possibly resulting in her death.

PLAINTIFF EDNA KOLMAN

44. Plaintiff Edna Kolman, is 87 years of age and has been a resident of Crown Nursing Home, a skilled nursing

facility at 3457 Nostrand Avenue, Brooklyn, New York, for approximately nine (9) years.

45. Plaintiff suffers from cataracts in both eyes. She is only ambulatory for a few feet from her wheelchair; she has a history of cardiac problems and is incontinent at times. Plaintiff also suffers from arterialsclerosis and has dizzy spells.

46. Plaintiff requires constant supervision in taking medication and in her special diet. She needs aid in bathing. On or about July 20, 1977 plaintiff suffered a dizzy spell while in her bathroom causing her to fall and strike her head on the tile and resulting in medical treatment.

47. Plaintiff requires nursing and therapeutic care every day of the week.

48. Plaintiff pays the nursing home every month from her monthly Social Security check towards her health care (leaving her a personal allowance of $28.50). All other health care costs are paid for by Medical Assistance payments (Medicaid).

49. On or about March 10, 1977, plaintiff's daughter, Sylvia Pizzi was informed that she was recommended for transfer and that she could request a fair hearing. Plaintiff personally received no written or oral notice of any kind.

50. On or about March 1977, plaintiff's daughter, Sylvia Pizzi, requested a fair hearing from the State Department of Social Services, Fair Hearing Section.

51. Neither plaintiff nor her representative received any documents or notice of access to documents prior to the fair hearing.

Intervenor Complaint—Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy

52. A hearing was held on June 8, 1977 at the skilled nursing facility before John M. Burke, State Hearing Officer. On information and belief Form DMS-1 was introduced as evidence. No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need skilled nursing and other health care was presented.

53. The Utilization Review Committee, in making the determination on the DMS-1, had looked only at plaintiff's medical records and never saw or spoke to plaintiff.

54. At the fair hearing, plaintiff's representative, Ms. Pizzi, presented evidence of her medical condition as stated in paragraphs 44-47 above. She presented at the hearing Progress Notes from previous years signed by Dr. Fletcher which stated: "After a careful review of Mrs. Kolman's records, it is my opinion that she continues to require nursing home care and not be transferred to another facility. She is a known cardiac for many years. Has . . . [unclear] . . . not able to care for self. After 6 years in this facility transfer would also be severe psychological trauma if any changes were made."

55. Plaintiff's representative asked to see her medical records at the hearing. The request was denied.

56. On or about September 19, 1977, plaintiff received a Decision After Fair Hearing dated September 13, 1977, and signed by Carmen Shang, Acting Commissioner and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of plaintiff's ineligibility to remain at the skilled nursing facility. On its face, that Decision indicates that consideration was given only to the finding of the

Utilization Review Committee and states merely that plaintiff presented no medical evidence to establish her need for nursing home care.

57. Neither the Hearing Officer nor the Decision of the Commissioner considered all of the medical evidence. Neither the Hearing Officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

58. Plaintiff is in immediate danger of being transferred out of the skilled nursing facility in which she now resides. Unless Medicaid payments are ordered to be continued, the Facility threatens to transfer plaintiff against her will very shortly. The Health Related Facility to which plaintiff will be transferred provides a lesser level of care and supervision and no skilled nursing care which plaintiff requires.

59. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the skilled nursing facility in which plaintiff resides, plaintiff has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma. This transfer might harm plaintiff beyond repair by worsening her medical condition and even possibly resulting in her death.

PLAINTIFF JAMES LUNDY

60. Plaintiff James Lundy is 65 years of age and has been a resident of River Manor, a Health Related Facility at 630 East 104th Street, Brooklyn, New York since No-

vember 10, 1975. He resides there with his wife Philomena Latona Lundy.

61. Plaintiff suffers from cerebral degeneration and other ailments.

62. Plaintiff sees the psychiatrist Dr. Briskin regularly. He requires observation.

63. Plaintiff requires nursing and therapeutic care every day of the week.

64. Plaintiff pays about $131.50 per month from his monthly Social Security check towards his health care (leaving him a personal allowance of $28.50). All other health care costs are paid for by Medical Assistance payments (Medicaid).

65. On or about December 27, 1976 a letter was received by Ms. Pons, plaintiff's relative informing her that plaintiff was recommended for transfer and that he could request a fair hearing.

66. On or about April 27, 1977, Ms. Ann Zlotnick, the social worker, requested a fair hearing from the State Department of Social Services, Fair Hearing Section.

67. Neither plaintiff nor his representative received any documents or notice of access to documents prior to the fair hearing, except for the DMS-1, which plaintiff's representative obtained from the Health Related Facility.

68. A hearing was held on November 1, 1977 at the Health Related Facility before Bernard Rostanski, State Hearing Officer. At the hearing, the City Department of

Social Services was present. Form DMS-1 was introduced as evidence. No evidence of a determination by the City Department of Social Services was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

69. The Utilization Review Committee, in making the determination on the DMS-1, had looked only at plaintiff's medical records and never saw or spoke to plaintiff. Plaintiff's physician, Dr. Nichols, had been informed of the Utilization Review recommendation, had disagreed with the decision, and appealed the decision, presenting his case for disapproval in writing.

70. At the fair hearing, plaintiff's representative, Bea Oaks, presented evidence of plaintiff's medical condition as stated in paragraphs 61-63 above. She further argued that the trauma of transfer to a different facility would be detrimental to plaintiff's health and life. Plaintiff testified that being separated from his wife who is in the Facility and needs Health Related care would have an adverse effect on him.

71. On or about November 22, 1977, plaintiff received a Decision After Fair Hearing dated November 18, 1977, and signed by Carmen Shang, Acting Commissioner and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of plaintiff's ineligibility to remain at the Health Related Facility. On its face, that Decision indicates that consideration was given only to the finding of the Utilization Review Committee and states merely that plaintiff presented no medical evidence.

72. Neither the Hearing Officer nor the Decision of the Commissioner considered all of the medical evidence nor

the effect on plaintiff of separation from his wife. Neither the Hearing Officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

73. Plaintiff is in immediate danger of being transferred out of the Health Related Facility in which he now resides. Unless Medicaid payments are ordered to be continued, the Facility threatens to transfer him against his will. The Adult Home to which plaintiff will be transferred receives no Medicaid Reimbursement and as a matter of law can provide no nursing or other health related care.

74. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the Health Related Facility in which plaintiff resides he has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma. This transfer might harm plaintiff beyond repair by worsening his medical condition and even possibly resulting in his death.

PLAINTIFF PHILOMENA LATONA LUNDY

75. Plaintiff Philomena Latona Lundy is 62 years of age and has been a resident of River Manor, a Health Related Facility at 630 East 104th Street, Brooklyn, New York since September 17, 1976. She resides there with her husband, James Lundy.

76. Plaintiff suffers from body pains and anxiety which aggravates her pains. She had a masectomy and has

resulting pain. Plaintiff has had back pain and swelling, and ear and leg pain. She has arthritis in her fingers, nervousness, loss of hearing and skin rash. She coughs and is subject to falls. Plaintiff is agitated and depressed.

77. Plaintiff requires constant supervision in taking medication. She takes valium and Tylenol. She receives regular psychiatric counselling.

78. Plaintiff requires nursing and therapeutic care every day of the week.

79. Plaintiff pays from her monthly Supplemental Security Income check towards her health care (leaving her a personal allowance of $25). All other health care costs are paid for by Medical Assistance payments (Medicaid).

80. On or about April, 1977, a social worker at River Manor verbally informed plaintiff she was recommended for transfer and that she could request a fair hearing. Plaintiff received no written notice of any kind.

81. On or about April 29, 1977, Mrs. Ann Zlotnick the social worker requested a fair hearing for plaintiff from the State Department of Social Services, Fair Hearing Section.

82. Neither plaintiff nor her representative received any documents or notice of access to documents prior to the fair heearing, except for the DMS-1, obtained by her representative from the Health Related Facility.

83. A hearing was held on November 1, 1977 at the Health Related Facility before Bernard Rostanski, State Hearing Officer. At the hearing, the City Department of

Social Services was present. Form DMS-1 was introduced as evidence. No evidence was presented. No other evidence to show that plaintiff did not need nursing and other health related care was presented.

84. Upon information and belief, the Utilization Review Committee, in making the determination on the DMS-1, had looked only at plaintiff's medical records and never saw or spoke to her. Plaintiff's physician, Dr. Nichols, had been informed of the Utilization Review recommendation, had disagreed with the decision, and appealed the decision, presenting his case for disapproval in writing.

85. At the fair hearing, plaintiff's representative Bea Oaks, presented evidence of her medical condition as stated in paragraphs 76-78 above. She further argued that the trauma of transfer to a different facility would be detrimental to plaintiff's health and life. She introduced a report from Dr. Gold stating plaintiff's psychiatric condition. The social worker Ms. Zlotnick testified on plaintiff's medical and psychological history.

86. On or about November 22, 1977, plaintiff received a Decision After Fair Hearing dated November 18, 1977 and signed by Carmen Shang, Acting Commissioner and Peter Mullany, Assistant Counsel to the New York State Department of Social Services. That Decision affirmed the determination of plaintiff's ineligibility to remain at the Health Related Facility. On its face, that Decision indicates that consideration was given only to the finding of the Utilization Review Committee and states merely that plaintiff failed to present sufficient medical evidence.

87. Neither the Hearing Officer nor the decision of the Commissioner considered all of the medical evidence.

Intervenor Complaint—Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy

Neither the Hearing Officer nor the Decision of the Commissioner stated the standard by which the Utilization Review Committee recommendation is reviewed. The Decision of the Commissioner simply adopted the finding of the Utilization Review Committee.

88. Plaintiff is in immediate danger of being transferred out of the Health Related Facility in which she now resides. Unless Medicaid Payments are ordered to be continued, the Facility threatens to transfer her against her will. The Adult Home to which plaintiff will be transferred receives no Medicaid reimbursement and as a matter of law can provide no nursing or other health related care.

89. Because of the adverse determination of the Utilization Review Committee and the Commissioner, and the resulting threat of transfer out of the Health Related Facility in which she resides, plaintiff has suffered and continues to suffer extreme mental and emotional distress and great hardship, humiliation and trauma. This transfer might harm plaintiff beyond repair by worsening her medical condition and even possibly resulting in her death.

* * *

Dated: New York, New York
December 12, 1977

Yours & etc.,

[Attorneys' subscriptions and office addresses omitted in printing.]

Attorneys for Plaintiffs-Intervenors

January 4, 1978 Hearing (Excerpts)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

76 Civil 3360

WILLIAM YARETSKY, RALPH CUEVAS and THE GRAY PANTHERS, NEW YORK CHAPTER,

Plaintiffs,

vs.

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF and PAULINE ASHKENAZY, on behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors,

vs.

CARMEN SHANG, individually and as acting Commissioner of the New York State Department of Social Services; ROBERT P. WHALEN, M.D., individually and as Commissioner of the New York State Department of Health; and J. HENRY SMITH, individually and as Commissioner of the New York City Department of Social Services,

Defendants.

Before: HON. CONSTANCE BAKER MOTLEY, District Judge

New York, New York
January 4, 1978—10:15 a.m.

[Appearances omitted in printing.]

* * *

[8] The Court: All right. Are plaintiffs ready to proceed with this hearing on their motion for preliminary injunction?

Mr. Goldfarb: Yes, your Honor, plaintiffs are ready.

Your Honor, we would like to begin, before calling our witness, to introduce some evidence on the issue of the notice.

I have five notices, which I would like to have marked in evidence and shown to the other side. All of these notices have been attached to the affidavits and they are uncontroverted by any affidavit from the defendants.

The Court: These are the notices actually received by the plaintiffs and the intervenor plaintiffs?

Mr. Goldfarb: These are the notices received by relatives.

(Plaintiffs' Exhibits 1 through 5 marked for identification.)

The Court: All right. We have those exhibits now marked Plaintiffs' Exhibits 1 through 5. Is there any [9] objection?

Mr. Agree: No objection.

Mr. Goldfarb: No objection.

The Court: All right. Plaintiffs' Exhibits 1 through 5 received.

(Plaintiffs' Exhibits 1 through 5 received in evidence.)

The Court: All right.

Mr. Goldfarb: If I may, on those written notices, I would just like to say that the definition of "adequate," according to the regulations that both sides have presented, is a written notice which includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific regulation supporting such, and explanation of the individual's right to request an evidentiary hearing.

Now, none of those notices state the regulations upon which the action is based. None of them, we believe, give the reasons for the intended agency action. At the best

they say "You have been found to no longer need the level of care." That is like telling someone they are being taken off of welfare because they no longer need public assistance. That is not adequate notice.

An adequate notice should tell these people, many [10] of which appeared with only relatives or friends or alone at these hearings, that "The doctor has determined that you no longer suffer from the following conditions and that you no longer need a skilled nurse to dress your wounds and things as when you came in and therefore you can be transferred."

We don't feel that these meet the basic Federal regulations or a due process requirement.

I would also like to introduce into evidence at this time the affidavit of Rae Wolper, Rose Shulman, Bessie Rossoff and Pauline Ashkenazy, of which I have the originals from the court papers. All of these, and I can note the paragraphs, state that these people received oral notice, these four persons, and they did not receive any written notice.

The Court: Are they relatives?

Mr. Goldfarb: No. These are the actual people in the nursing homes.

The Court: Are they different from those shown by Exhibits 1 through 5?

Mr. Goldfarb: Yes. It is different in that these people were not given any kind of written notice at all. They were told orally by someone in the nursing home.

[11] Also in the affidavits it states that each of those four persons requested to see their medical record and that request was denied. These affidavits have been presented in the order to show cause to the defendants and there is no affidavit or any information contradicting this in evi-

dence at all or presented by either the State or City defendant.

The Court: All right. Are they all together in one document?

Mr. Goldfarb: Yes.

The Court: Let's have it marked as Plaintiffs' Exhibit 6.

(Plaintiffs' Exhibit 6 marked for identification.)

The Court: Any objection to Plaintiffs' Exhibit 6?

Mr. McKay: Yes, your Honor. We would object to the admission of those affidavits because they contain several allegations concerning not only the notice but the discovery they were permitted or not permitted, as the case may be, and there are several issues raised there which are extremely difficult to verify without cross-examining the persons themselves. So on those grounds I would object to the admission of these affidavits.

[12] The Court: Have you submitted a counter-affidavit disputing these statements?

Mr. McKay: We do not have a counter-affidavit disputing a lot of the statements made in these affidavits, one of the reasons being that we would have to cross-examine the witness to find out whether some of the statements made were in fact accurate.

The Court: I thought that was why this case was recessed, to give you an opportunity to get the facts. And we recessed this case a couple of times for—

Mr. McKay: Yes, your Honor, we did.

The Court: —that purpose, to give you a chance to see what was what here.

Mr. McKay: That is true, to give us a chance to investigate the allegations made by the plaintiffs.

The Court: All right. Overruled. Received.

Mr. Goldfarb: For the record I would like to note the fact that in each of these affidavits, in the affidavit of Rae Wolper at Paragraph 6, it states that she received a verbal notice and at Paragraph 8 it states that she did not have access to the documents. In the affidavit of Rose Shulman, in Paragraph 7 it states that she received only verbal notice and in Paragraph 10 it states she did not receive any statements or any notice of [13] access to documents. In the affidavit of Bessie Rossoff, in Paragraph 8 it states that she received only verbal notice and in Paragraph 10 it states that she requested the documents and was denied access to her medical records. And in the affidavit of Pauline Ashkenazy, it states in Paragraph 8 that she received verbal notice and in Paragraph 10 it states that she requested documents but was not shown her medical records.

(Plaintiffs' Exhibit 6 received in evidence.)

Mr. Goldfarb: As to these four individuals, I would also like to introduce in evidence a mailgram which I received from the nursing home stating that "Unless you promise in writing to assure payments beyond the allocated 15-day grace period provided for fair hearing decision implementation," signed by both the Department of Health and the Department of Social Services, "we will, pursuant to rule, unfortunately, be forced to transfer those residents by the end of the working day of Thursday, 12/1/77. We await your response and thank you for your prompt consideration."

This is an exact copy of the message sent to Dr. N. Mishlin, care of New York State Department of Health, 2 World Trade Center.

The Court: Who sent the telegram and to whom?

[14] Mr. Goldfarb: The Park Manor Nursing Home. The original telegram went to the Department of Health.

He sent a copy to myself stating that he was transferring them unless there was either some type of court action or that the Department of Health guaranteed the Medicaid payments. We are introducing it to show the necessity and the harm that will come to our patients as proof that they will be transferred.

The Court: All right. Any objection to this? Let it be marked as Plaintiffs' Exhibit 7.

(Plaintiffs' Exhibit 7 marked for identification.)

Mr. McKay: Your Honor, I object to this as being irrelevant to the issues that are before the Court today. It involves a notice to the Park Shore Manor Home concerning the issue, or the statement, that these patients will be transferred due to Utilization Review Committee determinations that they no longer need the level of care provided at the home they are presently being cared for in. There is no question that when people are found ineligible to stay at one home that they will be transferred to another home with a lesser level of care. I don't see how this document adds to that general policy.

The Court: That is proof of the policy. That [15] is what this hearing is about, to prove what the plaintiffs claim. That is not a reason for not admitting the document. It doesn't go to the admissibility of the document. Overruled.

(Plaintiffs' Exhibit 7 received in evidence.)

* * *

[24] Mr. Gassel: Your Honor, at this time I would also like to mark for identification the two affidavits submitted by the State this morning. One is the affidavit of Donald B. Davidoff, with the exhibits attached to it. The other is the affidavit of William St[ei]bel, who is identified as Deputy Commissioner, Division of Medical As-

sistance, New York State Department of Social Services, and the attachment to it. * * *

* * *

[25] Mr. Gassel: [Exhibit] No. 10 [for identification] is Mr. Davidoff's affidavit [Record on Appeal Document No. 18] and [Exhibit] No. 11 [for identification] is Mr. Steibel's affidavit [Record on Appeal Document No. 20].

Q. Mr. Robert, I ask you to look at Exhibit 10 and Exhibit C of that exhibit, which is the hospital memorandum 77-119, and the notice attached to it.

I would also like you to look at Exhibit 11, and to Exhibit I of that Exhibit 11, which is administrative letter, 77 Adm 124.

You will notice, Mr. Robert, that there are annexed to one of those exhibits a form of a notice to be sent out to clients in cases of these Utilization Review or similar determinations.

* * *

Mr. Gassel: I am referring to Mr. Davidoff's affidavit, and Mr. Steibel's affidavit attached to Mr. [26] Davidoff's affidavit is hospital memorandum 77-119, which the State says it just issued, which is a purported new form notice, your Honor.

* * *

January 5, 1978 Order Issuing Preliminary Injunction and Dismissing Action Against City Defendant

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

CIVIL ACTION
No. 76 Civ. 3360 (CBM)

ORDER

WILLIAM YARETSKY, RALPH CUEVAS and THE GRAY PANTHERS, NEW YORK CHAPTER,

Plaintiffs,

vs.

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF and PAULINE ASHKENAZY, SADIE BIRENSWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY, and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors,

vs.

BARBARA BLUM, individually and as acting Commissioner of the New York State Department of Social Services; ROBERT WHALEN, M.D., individually and as Commissioner of the New York State Department of Health; and J. HENRY SMITH, individually and as Commissioner of the New York City Department of Social Services,

Defendants.

In the above-entitled action, a motion having been made by plaintiffs and plaintiffs-intervenors for the issuance of a preliminary injunction, and a motion having been

made by defendant J. Henry Smith for an order dismissing this action as against him on the grounds that he is not a proper party defendant herein, and the Court having certified this action as a class action on December 13, 1977, and the Court having conducted an evidentiary hearing on the above motions on January 4, 1978, and the Court having considered all the evidence presented at the hearing and the briefs, papers, and arguments of the parties, and the Court having issued its oral decision on January 4, 1978 granting defendant Smith's motion for dismissal and on January 5, 1978 granting plaintiffs' motion for a preliminary injunction, it is hereby

ORDERED (1), pursuant to Rule 21 of the Federal Rules of Civil Procedure, that the above-entitled action is dismissed as against defendant J. Henry Smith on the grounds that he is not a proper party defendant to this action; and it is further

ORDERED (2), pursuant to Rule 65 of the Federal Rules of Civil Procedure, that the defendants Barbara Blum, individually and as acting Commissioner of the New York State Department of Social Services, and Robert Whalen, individually and as Commissioner of the New York State Department of Health, and their successors in office, as well as their [CBM] officers, servants, employees, and agents including the proprietors and administrators of skilled nursing and health related facilities in New York State (hereinafter "nursing facilities"), and their respective employer and [CBM] agents, are hereby enjoined, and restrained pending a final determination of this action, from determining any of the plaintiffs-intervenors, in this action or any other person residing in a nursing facility in New York State who is a recipient of Medical Assistance (Medicaid) benefits (hereinafter "plaintiff class member")

to be ineligible to continue to receive the level of care at or to remain in the nursing facility in which he/she resides, from reducing or terminating the Medical Assistance (Medicaid) benefits of any plaintiff-intervenor or plaintiff class member for the level of care he/she is receiving, and from involuntarily transferring or discharging any such plaintiff-intervenor or plaintiff class member from the nursing facility in which he/she resides, unless in the case of any such plaintiff-intervenor or plaintiff class member the defendants afford such individual, after a recommendation by a Utilization Review Committee that such individual is ineligible to receive the level of care he/she is currently receiving, the following rights in addition to all other rights of that individual under law: (A) [CBM] timely and adequate written notice, given to the individual by a defendant or by an official of the State or a local Department of Social Services or Department of Health, that includes a statement of the proposed action, the specific regulations supporting such action, full [CBM] explanation of the individual's right to request an evidentiary state agency hearing, the circumstances under which assistance is continued if a fair hearing is requested, and the specific reasons for intended action in the form of a written statement setting forth in specific detail the changed medical conditions and other [CBM] circumstances of the individual which purportedly support the Utilization Review Committee recommendation that said individual no longer requires the level of care he/she is currently receiving, together with a copy of the completed form DMS-1, or form serving the function thereof, for that individual; and (B) [CBM] a fully adequate opportunity, and written notice of the right to that opportunity, for such individual and/or [CBM] his/her duly authorized representative to have unencumbered access to and to examine, at a reasonable time before the date

of that individual's fair hearing as well as during the hearing, the contents of all of that individual's case files and records and medical files and records, all documents and records to be used against that individual at the hearing, and all documents and records, medical or otherwise, which were relied on by the Utilization Review Committee in making the ~~initial~~ adverse recommendation, [CBM] including all of such medical documents and records which are at the nursing facility in which the individual resides; and it is further

ORDERED (3), that defendants and their employees and agents are enjoined and required to give to each plaintiff-intervenor and to each plaintiff class member who has already received an adverse Utilization Review Committee recommendation and who has not yet been transferred or discharged from his/her nursing facility a new notice and opportunity to have access to records and documents, in full accordance with the requirements of subparagraphs (A) and (B) of paragraph [CBM] (2) above; and it is further

ORDERED (4), that within 10 [CBM] business days after the date of the within Order, defendant Blum shall send, together with a copy of the within Order, an administrative letter or memorandum to every local or county Department of Social Services in New York State, and defendant Whalen shall send, together with a copy of the within Order, a hospital memorandum to every skilled nursing and health related facility in New York State, each stating that no plaintiff-intervenor and no plaintiff class member shall be transferred or discharged from his/her nursing facility or shall have his/her Medicaid benefits reduced or terminated unless such individual is afforded each and every right due him/her under this Order; and it is further

ORDERED (5), that defendant Whalen shall immediately send or cause to be sent a telegram to every skilled nursing and health related facility in New York State stating that the directive contained in hospital memorandum 77-122, dated 12/30/77 (attached hereto) [prohibiting the implementation of negative RHCF Utilization Review Committee determinations] shall remain in effect until further notice; and defendant Whalen may provide notice of the termination of said memorandum upon the transmittal of the hospital memorandum required by paragraph (4) above.

Dated: New York, New York
[CBM] January 5, 1978.
5:30 p.m.

/s/ CONSTANCE BAKER MOTLEY
United States District Judge

January 10, 1978 Opinion on Preliminary Injunction, Class Certifiation and Dismissal of City Defendant

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

[Appearances omitted in printing.]

CONSTANCE BAKER MOTLEY, D. J.

MOTION FOR PRELIMINARY INJUNCTION

Findings of Fact and Conclusions of Law

Plaintiffs are all elderly residents of skilled nursing home facilities and intermediate care facilities located in the State of New York. Each plaintiff is the recipient of Medicaid benefits made available as a result of New York State's medical assistance program. Each plaintiff has been notified that his or her benefits will be reduced or terminated, thus necessitating a transfer of plaintiff to a facility with a lower level of care.

The transfer becomes necessary because of plaintiff's inability to pay for the present level of care after reduction or termination of benefits.

The claim on this motion for preliminary injunction is that the determination to reduce or terminate plaintiff's Medicaid benefits in each instance was made without due

process of law in violation of the due process clause of the Fourteenth Amendment to the Federal Constitution and the federal and state statutes and regulations governing the Medicaid program. More specifically, plaintiffs claim that the determination in each case was made without: 1) adequate notice to plaintiff of the reasons for the determination and 2) without affording plaintiff, or his/or her representative an opportunity to examine the individual plaintiff's medical records at the nursing home facility in order that plaintiff might take meaningful advantage of the opportunity afforded for a review hearing and be prepared to refute the merits of the determination. Plaintiffs claim that the right to adequate notice and opportunity to discover, reasonably in advance of any hearing, relevant medical evidence and to present medical evidence at the hearing are rights protected not only by the Constitution but specifically provided for by the statutes and regulations. 45 CFR § 205.10(a)(4)(i)(B); 18 N.Y.C.R.R. § 358.8; 18 N.Y.C.R.R § 360.33(a)(1); 45 CFR § 205.10(a)(13).

This court's jurisdiction is therefore properly invoked under the provisions of Title 28, U.S.C. § 1343(3) and 1331(a) and Title 42, U.S.C. § 1983. *Feld* v. *Berger*, 424 F. Supp. 1356 (S.D.N.Y. 1976).

The State's program was established pursuant to the requirements of Title XIX of the Federal Social Security Act, 42 U.S.C. Sections 1396, *et seq.*, and regulations promulgated pursuant thereto. These statutes and regulations establish the standards which the State's program must meet and follow in order to qualify for federal financial assistance by way of reimbursement.

The State's program is administered by two State agencies, the Department of Social Services and the Department of Health. The Commissioner of each state

agency has been made a defendant in this action. The State's Department of Social Services is responsible under state law for administration of the entire public assistance program in the State, including the medical assistance program known as Medicaid. The Department of Health is responsible for administration of certain aspects of the Medicaid program and for licensing and supervising the operation of skilled nursing homes and other health-related facilities in New York State.

The funds provided each plaintiff by the State's program pay for that portion of the plaintiff's health care needs which the plaintiff is financially unable to meet and which are provided by the nursing home facility in which the plaintiff resides. Each plaintiff must therefore qualify both medically and financially for Medicaid benefits. This means that each plaintiff's entitlement to benefits and the level of such benefits are subject to periodic review and redetermination as required by statute. 42 U.S.C. § 1396a (26); 45 C.F.R. §§ 250.18(a)(1)(iii) and 250.19.

Pursuant to the review requirements, a Utilization Review Committee (the Committee) is required to be established in each skilled nursing facility (SNF) and each intermediate care facility (ICF) consisting of two or more physicians with participation from other professional personnel. The Committee cannot consist of physicians or other personnel on the staff of any facility or financially interested in such facility. 45 C.F.R. § 250.19(a)(3)(ii) (A) and (B). Patients in a SNF are to be reviewed by the Committee every 90 days to determine the need for continued stay and patients in an ICF are reviewed every 6 months. 45 C.F.R. § 250.19(a)(3)(viii) (B) and (4) (vi). The review of continued stay cases are conducted by the Committee or a designee of the Committee. (Brief of State Defendants filed 1/5/78, p. 4-5). Any case which does not meet the criteria developed to assess the neces-

sity for continued stay must be reviewed by a group which includes at least one physican. If the group does not believe that continued stay is medically necessary, it must notify the patient's attending physician and afford him an opportunity to present his views. If the attending physician does not present any additional information, the decision of the Committee is final. However, if the attending physician offers additional information and disagrees with the decision, two physicians must approve the Committee's decision. 45 C.F.R. § 250.19(a) (3) (ix), (C), (D), (E), (F) and (G).

Written notification of the Committee's decision is to be sent to the attending physician, the facility administrator, the patient, and where possible, his next of kin, and the single state agency in charge of the program. Notice must be given no later than two days after the final decision, but in no case later than three working days after the assigned review date. 45 C.F.R. § 250.19(a)(3)(ix)(F).

New York's regulations require that each facility comply with the foregoing federal regulations. 10 N.Y.C.R.R. §§ 416.9, 421.13 and 731.11. In New York the final determination that the continued stay is not medically necessary may be made by one physician where the attending physician does not contest the decision. 10 N.Y.C.R.R. § 731.11(j).

The federal and state regulations require that notice of termination or reduction be "mailed at least 10 days before the date . . . upon which the action would become effective." 45 C.F.R. § 205.10(a)(4)(i)(A); 18 N.Y.C.R.R. § 358.8(a)

The foregoing facts are not in dispute. What is disputed is 1) whether adequate notice was given as required to each plaintiff of the reason or reasons for the determination to reduce or terminate benefits and

2) whether plaintiffs or their representatives were given an opportunity to review the medical records at the nursing facility in order that they might take meaningful advantage of their right to a review of the determination and to present relevant medical evidence.

On the hearing of plaintiff's motion for preliminary injunction,[1] the evidence established that each plaintiff received some kind of notice and exercised his or her right to a review hearing, but in no case did a plaintiff receive the notice required by statutes and regulations governing the Medicaid program and in no case (except Foley) did a plaintiff have access to medical records at the facility in which that plaintiff was located (and which presumably formed the basis of the determination) at any time before or at the hearing.

In each instance a Department of Health form known as DMS-1 was filled out by a registered nurse at the nursing facility in which the plaintiff resides.[2] These forms constitute the first written recordation of the Committee's determination to transfer the plaintiff to a lower level of care. In addition to noting the patient's personal history, the DMS-1 form makes note of the diagnoses occasioning initial use of the facility, significant medications and surgery, if any, nursing care and therapy required, the patient's function status, mental status and impairments, whether the patient is incontinent, requires special diet, and a determination as to whether there is a high probability that complications would arise without

---

[1] The motion for preliminary injunction was brought on by the intervenor plaintiffs, therefore all references to plaintiff in this case are to the intervenor plaintiffs. With respect to the two original individual plaintiffs, William Yaretsky and Ralph Cuevas, it is believed that Yaretsky is deceased and Cuevas has been discharged from his particular facility.

[2] Plaintiffs' Exhibits 6, 8.

skilled nursing care. This form in each case was signed by one physician who is apparently a member of the committee.

The form of written notice which each plaintiff thereafter received varied,[3] but showed conclusively that the reason given for the determination to reduce benefits and transfer the patient to a lesser care facility was vague and wholly conclusory. In the case of plaintiff Mary Foley, for example, her notification reads, in part, as follows: 'Our Utilization Review Committee has had a meeting as of April 14, 1977 and has recommended Miss Foley to a Health Related Facility. In the opinion of the physicians, she is not in need of skilled nursing care."[4]

In the case of plaintiff Rae Wolper, no written notification was given her as required. She was notified orally by a social worker in the facility in which she is located that a decision had been made to transfer her.[5] The social worker notified plaintiff Wolper of her right to a fair hearing which was thereafter requested. Neither plaintiff nor her representative received any documents or notice of where to obtain access to documents prior to the fair hearing.[6] At the hearing Miss Wolper's Form DMS-1 was introduced in evidence. This was the only evidence on which the State relied. Miss Wolper's medical records were not produced at the hearing. Miss Wolper's representative at the fair hearing, Beatrice Oaks, a paralegal, requested the opportunity to review this plaintiff's medical records on which the determination was ap-

---

[3] Plaintiffs' Exhibits 6, 8.

[4] Plaintiffs' Exhibit 4. See also Plaintiffs' Exhibits 1, 2, 3, and 5 and 8.

[5] Plaintiffs' Exhibit 6.

[6] Plaintiffs' Exhibit 6.

parently made. The hearing was held at the nursing facility in which Miss Wolper resides. The request was denied. A similar request had been made before the hearing at the nursing facility. Miss Oaks, who represents nursing home patients, testified that she made a point of asking for the records in Miss Wolper's case to make sure that the policy was to refuse access to the underlying medical records since she represented other persons similarly situated.

Charles Robert, who represents nursing home patients in Nassau County, New York, testified to the same effect with respect to the availability of records and set forth in his affidavit specific instances when medical records were requested and not produced.[7]

In the case of Miss Wolper, the decision after the hearing reads in part as follows: "The record in this case establishes that the Utilization Review Committee reported to the agency on June 24, 1977 that appellant no longer required continued care in a Health Related Facility and recommended her transfer to an Adult Home. Although appellant objects to such transfer, she failed to present sufficient medical evidence to establish her need for continued care. . . . Accordingly, based on the medical evi dence presented at this hearing, the agency's determination was proper."[8]

Miss Wolper's private doctor had written a letter advising that her hypertension required close monitoring of her blood pessure, but this was viewed as insufficient ground for reversal of the original decision to transfer Miss Wolper from an ICF (Health Related Facility as distinguished from a Skilled Nursing Facility) to an Adult

---

[7] Plaintiffs' Exhibit 9.

[8] Plaintiffs' Exhibit 6.

Home which has no medical facility or aid.[9] Since there was no access to the nursing home medical records by Miss Wolper's representative, and no records were produced at the fair hearing, the determination to transfer based on the Form DMS-1 could not be effectively challenged.

Plaintiffs Rose Shulman, Bessie Rossoff, and Pauline Ashkenazy all similarly received verbal notification from the social worker of the facility in which they reside of the decision to transfer. They were likewise represented at their fair hearing, which takes place at the facility, by Beatrice Oaks who testified that access to medical records was denied and that the only evidence relied on by the state was the Form DMS-1 in each case.

In the case of Sadie Birenzweig, the only notification was to her daughter who was verbally informed of the decision to transfer by the social worker.[10] She was represented at the fair hearing by her son and daughter. Mrs. Birenzweig was not present at the hearing, although her presence was requested by her son. The hearing again took place in the facility in which this plaintiff resides. Neither her son nor her daughter were shown any medical records at the hearing and were not told the basis of the decision. Mrs. Birenzweig is 93 years old. She has had two strokes, has severe cataracts in her eyes, is hard of hearing, walks with a walker, has arteriosclerosis, high blood pressure, arthritis and memory defects, according to her unchallenged affidavit. She has been in a skilled nursing facility for about one year. Plaintiff Martha Zahl is 87 years of age and has been in a skilled nursing facility since July 28, 1972. Plaintiff Edna Kolman is 87 years of age and has been in a skilled nursing facility for approximately nine years.

---

[9] Plaintiffs' Exhibit 6.

[10] Plaintiffs' Exhibit 8.

Adequate notice is defined by the federal regulations as follows:

> "(B) 'Adequate' means a written notice that includes a statement of what action the agency intends to take, the reasons for the intended agency action, the specific regulations supporting such action, explanation of the individual's right to request an evidentiary hearing, . . . and the circumstances under which assistance is continued if a hearing is requested." 45 C.F.R. § 205.10(a)(4)(i)(B).

Under the State's regulations adequate notice is defined in part as follows:

> "(2) *Adequate advance notice* means a written notice that includes details of reasons for the proposed action, . . ." 18 N.Y.C.R.R. § 358.8(a).

The court finds that the "adequate" written notice was not given to plaintiffs or their next of kin or representatives. In those cases where written notice was given that written notice was manifestly inadequate to advise the plaintiff of the underlying medical reasons for the decision to transfer.

In *Feld* v. *Berger,* 424 F.Supp. 1356 (S.D.N.Y. 1976) this Court (Weinfeld, J.) has already ruled that a Medicaid claimant or his representative is entitled to "timely" notice and an opportunity to examine his or her file at a reasonable time before the hearing and at the hearing in accordance with federal regulations. 45 C.F.R. 205.10(a)(13)(i). This includes the right to examine all documents and records to be used by the State at the hearing. And there appears to be no statutory or other bar to a request to review a claimant's file, *after a decision to transfer has been made* by the Committee and claimant so notified, in

order that the claimant or his or her representative can make an informed decision whether to request a hearing. To invoke the right to review without any basis therefor is certainly not to be encouraged in the context of Medicaid fair hearings any more than it is to be encouraged in any other legal context. The State suggested at the hearing of plaintiffs' motion for preliminary injunction that plaintiffs' right to see the medical records arises only after the plaintiff has requested a fair hearing as the regulation reads, then if plaintiff finds there is no basis for an appeal, plaintiff can then withdraw the request for a hearing. This suggestion was made in reply to plaintiffs' request to be allowed the right to see the records after the Committee determination. The court sees no logic in this suggestion. It seems far more logical and far more consonant with the spirit of the regulations to permit a plaintiff to see the records, when requested, before an appeal is needlessly invoked. The suggestion that the records contain information which might upset the patient if it became known has already been raised and rejected. *Feld* v. *Berger, supra,* at 1363.

The record discloses that Foley apparently had access to nurses notes. Her representative did not see prior DMS-1 forms for comparison with the current one relied on by the State.

The court finds that plaintiffs have shown a clear probability of success on the merits of their claim that they are entitled to "adequate" notice and an opportunity to see the medical records before and at the hearing as required by federal regulations. In *Feld* v. *Berger, supra,* although Judge Weinfeld referred specifically to the requirement of "adequate" notice the issue there emphasized was "timely" notice, i.e. whether persons such as plaintiffs are entitled to notice at all. A statement of the underlying medical reasons for termination or reduction, as the

Federal and State regulations require, are manifestly necessary in order to enable a Medicaid claimant to prepare an intelligent appeal or to conclude that no appeal is warranted. Plainly no hearing can be labeled fair which permits a Medicaid recipient to learn for the first time on appeal of the specific medical reasons for reduction or termination of Medicaid benefits.

It is too plain for argument that there is a possibility that these elderly and medically disabled plaintiffs will suffer irreparable harm if they are transferred from a SNF or an ICF in violation of statutory notice and fair hearing requirements. *Feld* v. *Berger, supra,* at p. 1359.

As Judge Weinfeld noted in *Feld* v. *Berger, supra,* at p. 1360 n. 12, the federal due process claims here are not frivolous. Medicaid benefits on which plaintiff must depend are being reduced or terminated. *Goldberg* v. *Kelly,* 397 U.S. 254 (1970). At stake for these plaintiffs are two fundamental interests which are constitutionally protected. These plaintiffs are being threatened with an action that for many of them will result in eviction from what is now their home. And in every case the plaintiff will sustain a reduction or termination of public assistance in the form of Medicaid benefits. In such a case, the due process clause requires minimum procedural safeguards which includes adequate notice of the *reasons* for reduction or termination and opportunity to be heard which includes an opportunity to discover and present evidence.

Consequently there are also sufficiently serious questions raised by plaintiffs going to the merits of their constitutional claims as to make them a fair ground for litigation with the balance of hardship tipping decidedly toward these plaintiffs. Plaintiffs have therefore met their burden on this motion for preliminary injunction. *Gresham* v. *Chamber,* 501 F.2d 687 (2d Cir. 1974).

This case has not been rendered moot by the new notice form issued by the Department of Health on 12-30-77.[11] That form, if applicable to plaintiffs, likewise fails to require *reasons* for the determination to reduce or terminate benefits and to advise plaintiffs and members of their class of their right to see their medical records at the nursing home in advance of the fair hearing.

An injunction will therefore issue enjoining defendants, pending a final determination of this action, in two respects: First, defendants will be enjoined from failing and refusing to provide each plaintiff, and others similarly situated, with reasons for any agency action, the result of which would be to transfer the plaintiff from the facility in which the plaintiff is presently residing to a lesser care facility or to otherwise reduce the amount of Medicaid assistance available to plaintiff. Second, defendants will be enjoined from refusing to permit plaintiff's access to all medical records of plaintiffs at the nursing home after the Committee decision.

Class Action Certification

This action was originally filed on July 28, 1976 on behalf of two individuals, William Yaretsky and Ralph Cuevas and the New York Chapter of the Gray Panthers. The State defendants answered on December 13, 1976. On April 8, 1977 an amended complaint was filed on behalf of the original plaintiffs and other persons similarly situated praying for class certification. On November 23, 1977 Mary Foley filed an intervenor complaint. On November 30, 1977, Rae Wolper, Rose Shulman, Bessie Rossoff and Pauline Ashkenazy filed an intervenor complaint. And on December 12, 1977 Sadie Birenzweig,

---

[11] Plaintiffs' Exhibit 13.

Martha Zahl, Edna Kolman, James Lundy and Philomena Latona Lundy filed an intervenor complaint.

On December 5, 1977 plaintiffs Mary Foley, Rae Wolper, Rose Shulman, Bessie Rossoff and Pauline Ashkenazy, were permitted to intervene and were granted a temporary restraining order restraining defendants, including their agents, the proprietors and manager of the Parkshore Manor nursing home, from discontinuing the eligibility of the plaintiffs-intervenors to remain in the facility as patients and from failing to continue uninterrupted their full levels of Medicaid assistance benefits for intermediate nursing care, and from transferring plaintiffs from the Parkshore Manor health related facility. J. Henry Smith, City Commissioner of the Department of Social Services was joined as a party defendant.

On November 22, 1977 intervenor plaintiff Mary Foley moved for a preliminary injunction on behalf of herself and others similarly situated. On November 28, 1977, this court entered an order setting a hearing for December 8, 1977 on the Foley motion, permitting Foley to intervene and restraining defendants from terminating her benefits pending the hearing.

On December 14, 1977 a similar order was entered on behalf of Foley, Wolper, Shulman, Rossoff, Ashkenazy, Birenzweig, Zahl, Kolman, James Lundy and Philomena Latona Lundy setting a hearing on a new motion for preliminary injunction for December 20, 1977, permitting Birenzweig, Zahl, Kolman, and the two Lundys to intervene, certifying the action as a class action, and issuing a temporary restraining order on behalf of these intervenors.

In *Feld* v. *Berger, supra,* plaintiffs had moved for class action determination. Judge Weinfeld ruled that he deemed class certification superfluous. In this connection he said: "The defendants are public officials charged with

compliance with and enforcement of federal as well as state laws. The Court assumes these public officials, mindful of their responsibilities, will apply the determination here made equally to all persons similarly situated. '[I]t would be unthinkable that the . . . defendants would insist on other actions being brought' to vindicate the same rights at issue here." He cited *Vulcan Society* v. *Civil Service Commission,* 490 F.2d 387, 399 (2d Cir. 1973) and other cases in support of his determination that class action certification would be unnecessary.

The defendants in the *Feld* case were the Commissioner of the New York State Department of Social Services and the Commissioner of the New York City Department of Social Services. The instant case and the *Feld* case were pending at the same time and, apparently, since Judge Weinfeld rendered his decision in the *Feld* case on December 28, 1976 holding that SNF and ICF patients were entitled to timely notice and also to an opportunity to review records prior to a hearing the instant action was not pressed. However, when it appeared that defendants in *Feld* were not complying with Judge Weinfeld's order, the intervenor plaintiffs here sought to intervene in this action which was awaiting class action certification, to move for such certification, and for preliminary relief.

As this Court has found, defendants here have not complied with the federal or state regulations with respect to "adequate"notice and have not allowed, with one possible exception, discovery of medical evidence in the nursing home file prior to a state fair hearing, contrary to the belief expressed by Judge Weinfeld that they would comply with the regulations and that additional legal action in this area would be unnecessary. Since Judge Weinfeld denied class action certification, the intervenors apparently concluded that they had no alternative except to intervene in this action and press for class certification or bring still

another action. This court previously ruled from the bench that the case would be certified as a class action in order to stem the flow of intervenor petitions. This determination is now reaffirmed and the court certifies that this action is properly maintainable as a class action.

What plaintiffs actually seek is certification of a sub-class, for the purposes of this motion for preliminary injunction, consisting of plaintiffs who have been determined by defendants to be ineligible to remain in the facility in which they presently reside and who have been denied by defendants adequate notice and access to documents and evidence prior to their fair hearings. That certification is granted. Rule 23(c)(1),(4). The court finds that the sub-class is so numerous that joinder of all members is impracticable. As indicated, there have been 10 individuals who have been allowed to intervene and counsel for these intervenors advised the court that others were seeking intervention. It appears from the evidence that there are numerous other persons similarly situated, all of whom need immediate relief from this court to prevent irreparable injury. The court also finds that there are common questions of law and fact relating to the sub-class. Rule 23(a)(2). These questions are whether defendants' failure to afford plaintiffs and members of their class "adequate" notice and discovery of relevant documents and evidence violates rights to due process and federal and state statutory requirements. The court finds that the claims of the representative parties are typical of other members of sub-class and that the plaintiffs will adequately represent the class. Counsel for intervenor plaintiffs are the Legal Aid Society of the City of New York, and the Legal Services for the Elderly Poor. Mobilization For Youth represents the original plaintiffs. These organizations have the legal resources and experience adequate to protect members of the sub-class and

are able to utilize their resources to protect the interest of all members of the sub-class. Rule 23(A)(4). Plaintiffs counsel have brought to the court's attention a number of class actions prosecuted by them on behalf of various plaintiffs in this court and other federal courts. Finally, the court finds that defendants have acted or have refused to act on grounds generally applicable to the sub-class thereby making appropriate final injunctive and other relief to the sub-class as a whole. Rule 23(b)(2). The court finds that the plaintiffs are not only entitled to have this action certified as a class action, *Percy* v. *Brennan*, 384 F.Supp. 800, 811 (S.D.N.Y. 1974); *Rodriguez* v. *Purcell*, 391 F.Supp. 38, 41 n.12 (S.D.N.Y. 1975), but that the class action is absolutely necessary to avoid further duplication of litigation with respect to the administration of the State's Medicaid program relating to long term nursing care facilities for the elderly.

The City's Motion To Dismiss

On January 3, 1978 the defendant New York City Commissioner of Social Services had moved to dismiss the action as to him on the ground that the state has taken charge of long term cases in the Medicaid field and the city is therefore not a proper party to this proceeding. The evidence at the hearing on plaintiffs' motion for preliminary injunction disclosed that as of July 5, 1977 the State Department of Health moved by a Hospital Memorandum of that date to supercede all other prior instructions regarding patients in or being admitted to Residential Health Care Facilities.[12] This action was taken pursuant to the New York State Legislature action in passing Medicaid cut-back legislation. (Chapter 77 of the Laws of 1977).

---

[12] Plaintiffs' Exhibit 14.

This memorandum sets forth the procedure for determining whether a patient is to be admitted to or continued in a particular facility.

On December 30, 1977 another Hospital Memorandum was issued by the State Department of Health advising skilled nursing facilities and health related facilities of their responsibility to notify Medicaid patients of their right to a fair hearing when Medicaid benefits are to cease because the present level of care is found to be unnecessary, inappropriate, or not a covered Medicaid benefit, and directing that such notification be made in writing.[13] It is therefore clear that as a result of the Medicaid cut-back legislation the State Department of Health has moved to take control of the utilization review process and continued aid process action. The City Commissioner of Social Services is, therefore, at the very least, an unnecessary party. Even if a city agency does perform some function with respect to the reduction or termination of the benefit as the local paying agent, this is done only after the determination has been made by the Committee at the facility pursuant to federal and state regulations and after a fair hearing. The city defendant's motion to dismiss is, therefore, granted.

Dated: New York, New York
January 10, 1978

s/ Constance Baker Motley
U. S. D. J.

---

[13] Plaintiffs' Exhibit 13.

February 17, 1978 Order Denying State Defendants Relief From January 5, 1978 Order Requiring Them to Notify Patients of Adverse Utilization Review Committee Decisions[*]

Motion to amend order to permit notice to be sent by facility as opposed to the state [CBM] [or] local public agency which makes the determination to discontinue or reduce benefits denied. Notice must be given by the latter.

So Ordered,

2/17/78 N.Y., N.Y.

s/ Constance Baker Motley
U.S.D.J.

---

[*] Handwritten endorsement by the district judge, document number 32 of the record on appeal, appears on the back of document number 29.—Ed.

January 16, 1979 Opinion of the Court of Appeals

UNITED STATES COURT OF APPEALS

FOR THE SECOND CIRCUIT

No. 13—August Term, 1978.

(Argued October 12, 1978 Decided January 16, 1979.)

Docket No. 78-7077

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, New York Chapter,

Appellees,

—and—

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY, and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Appellees,

—v.—

BARBARA BLUM, individually and as Acting Commissioner of the New York State Department of Social Services, ROBERT WHALEN, M.D., individually and as Commissioner of the New York State Department of Health,

Appellants.

Before:

LUMBARD and OAKES, *Circuit Judges*, and MACMAHON, *District Judge.**

Appeal from an order of the United States District Court for the Southern District of New York, Constance Baker

---

* Of the Southern District of New York, sitting by designation.

Motley, *Judge*, granting a preliminary injunction against proposed changes in the procedure for notifying residents of health care facilities of (1) decisions to transfer them to reduced care facilities, which entail a reduction or termnation of benefits, and (2) the patients' right to fair hearings to challenge such decisions. Held, this court has jurisdiction over the appeal even though appellants filed the notice of appeal during the pendency of a motion to amend the preliminary injunction; the district court correctly enjoined defendants from delegating to the health care facility the responsibility for notifying the patient of his fair hearing rights; and the district court properly refused to allow defendants to exclude "medically contraindicated" information from the records to which the patient may have access in order to prepare for the fair hearing.

Judgment affirmed.

[Appearances omitted in printing.]

PER CURIAM:

This is an appeal from an order of the United States District Court for the Southern District of New York, Constance Baker Motley, Judge,[1] dated January 5, 1978, but filed January 10, 1978. The order granted appellees' motion for a preliminary injunction against appellants to prevent them from failing to provide resident patients in health care facilities with timely and adequate written notice of the decision to transfer them to a reduced care facility and to reduce or terminate their Medicaid benefits. On January 19, 1978, appellants filed a motion under Fed. R. Civ. P. 59(e) to amend the preliminary injunction to allow the health care facility itself to provide the notice

---

[1] *Yaretsky* v. *Blum*, No. 76 Civ. 3360 (CBM) (S.D.N.Y. Jan. 10, 1978).

required of the state or local supervisory agencies and to withhold from the patient information in his file if disclosure was "medically contraindicated." On February 6, 1978, while the motion was pending, appellants filed a notice of appeal from the preliminary injunction. On February 21, 1978, the district court denied appellants' Rule 59(e) motion. On appeal, appellants raise essentially the two points that they made in the Rule 59(e) motion. Appellees defend on the merits the district court's preliminary injunction as issued, and thus the district court's denial of the Rule 59(e) motion, but they also question this court's jurisdiction over the appeal. We address the jurisdiction issue first.

Appellees argue that the notice of appeal was filed during the pendency of the Rule 59(e) motion and a premature notice of appeal is "a legal nullity." Appellants suggest that because they filed the Rule 59(e) motion fourteen days after the date of the district court's order, albeit nine days after the date of the filing of the order, the motion was untimely and thus did not toll the period for filing the appeal. We hold otherwise, however.

Although the district court's order was dated January 5, 1978, the clerk entered the order in the docket on January 10, 1978. Under Fed. R. App. P. 4(a), which speaks of the "entry of judgment" as the crucial date, and Fed. R. Civ. P. 58 and 79(a), which provide that a judgment becomes effective only when entered in the docket, the date of the entry in the docket, not the date of the order, begins the running of time for post-trial motions and appeals. *See, e.g., Neely* v. *Merchants Trust Co. of Red Bank,* 110 F.2d 525 (3d Cir. 1940); *see* 6A *Moore's Federal Practice* ¶ 58.03[1] (2d ed. 1973).

The appeal was thus premature. Although the filing of a notice of appeal within the prescribed time limits is a

jurisdictional prerequisite to the appeal itself, the better rule is that in the absence of prejudice to the appellee, the court should treat a premature appeal as from a final judgment so as to avoid denial of justice, expense, and inconvenience. This rule applies to appeals that are premature not only because they were filed between the pronouncement of judgment and the entry of judgment, *see Lemke* v. *United States*, 346 U.S. 325 (1953), but also because they were filed while a Rule 59 motion was pending. *See, e.g., Dougherty* v. *Harper's Magazine Co.*, 537 F.2d 758, 762 (3d Cir. 1976); *Stokes* v. *Peyton's Inc.*, 508 F.2d 1287 (5th Cir. 1975); *Song Jook Suh* v. *Rosenberg*, 437 F.2d 1098 (9th Cir. 1971); *see* 15 C. Wright, A. Miller & E. Cooper, *Federal Practice and Procedure* § 3915, at 599-600 (1976). Appellees have alleged no prejudice, nor could they, because they had notice of the grounds for appeal from the Rule 59(e) motion itself.

We thus reach the two issues raised on the merits. Appellants argue first that the district court erred in refusing to allow the health care facility itself to provide the notice to the resident patient of the decision to transfer him to a reduced care facility and to reduce or terminate his Medicaid benefits. The district court's order, which enjoined appellants from implementing this single notification procedure, required adherence to the dual notification procedure previously in effect. Under that procedure, the facility's Utilization Review Committee informs the patient of its decision that his continued stay at the facility is not medically necessary and that a lower level of care would be more suitable to his condition; the local social services agency or office then notifies the patient of his right to a fair hearing to review the Committee's decision and the due process rights to which the patient is entitled at the hearing. Appellants contend, although we note that there is no supporting evidence in the record, that the

dual notification procedure "proved to be cumbersome to administer, inefficient and confusing to the patient" and that the single notification procedure, by contrast, "would benefit the patient and help streamline the complex network of Medicaid regulations." But regardless of how we may feel about seemingly unnecessary bureaucratic red tape, the HEW regulations clearly require the state or local agency to provide the notice of transfer or reduction or termination of benefits, 45 C.F.R. § 205.10(a)(4)(i),[2] and further seem to preclude delegation of the responsibility. *Id.* § 205.100(b)(1).[3] Appellants cite no authority for allowing a private party such as the health care facility to provide the notice required by due process before the State can reduce public assistance benefits.

Moreover, it is not irrational to treat the functions of the Utilization Review Committee and the state and local social services agencies as diverse. As a part of the process of keeping a patient informed about his condition and proposed medical treatment, the Committee is the one to inform the patient of the decision to reduce the level of care that he is receiving; consistent with this doctor-patient framework, 42 C.F.R. § 450.19(a)(3)(ix)(F) requires the

---

[2] 45 C.F.R. § 205.10(a)(4)(i) provides that "the State or local agency shall give timely and adequate notice" in cases of proposed actions to reduce or terminate assistance. It does not permit notice to be given by a private party or "the Utilization Review Committee" of a private party.

[3] 45 C.F.R. § 205.100(b)(1) permits delegation "by other State or local agencies" but in no case permits delegation to a private party such as a health care facility or its "Utilization Review Committee." The dissenting opinion appears to equate such a committee with a state or local agency, a characterization with which we disagree; and we note that appellants make the further argument that *either* the Utilization Review Committee *or* the private health care facility itself should be allowed to provide the patient with notice of the reduction or termination of his Medicaid benefits and his fair hearing rights to challenge this determination.

Committee to provide this preliminary notice. The state agency, however, bears ultimate responsibility for informing the patient of the resulting reduction or termination of his health care benefits and advising him of his due process rights to a hearing to review the Committee's decision. If, as appellants contend, the proposed single notification system is clearly superior and would not result in the failure of patients to receive written notice of their fair hearing rights, as happened to appellees in this case, the remedy lies in persuading HEW to amend its regulations.[4] Neither appellants nor the court can unilaterally change the federally imposed notification procedure.

Appellants also challenge, in a somewhat appealing argument, the district court's refusal to exclude "medically contraindicated" information from the scope of the disclosure required of the agency to the patient preparing the defense that he will use at the fair hearing. The HEW regulations provide that "[t]he claimant, or his representative, shall have adequate opportunity . . . [t]o examine the contents of his case file and all documents and records to be used by the agency at the hearing at a reasonable time before the date of the hearing as well as during the

---

[4] In support of the suggested preference for the judgment of the state officials over that of the district court, the dissenting opinion states that "some patients will not receive notice under either system so long as it is administered by fallible human beings." However, the undisputed evidence is that none of the ten intervenor-appellants received *any* written notice whatsoever; the "notice" given to them was either a verbal notice to the patient, written or verbal notice to the patient's relative, or a combination of the two; and the "notice" was brief and conclusory, stating only that the patient would be transferred and that the patient could seek a fair hearing. Thus even if the notice procedure in this case had been proper, it was woefully inadequate. In addition, the burden, it seems to us, is on the State to presuade HEW to amend its regulations, not on private plaintiffs first to complain to HEW.

hearing." 45 C.F.R. § 205.10(a)(13)(i). Thus the regulations requiring disclosure do not facially exempt medically contraindicated information. *See Feld* v. *Berger*, 424 F. Supp. 1356, 1363 (S.D.N.Y. 1976); *cf. Areizaga* v. *Quern*, 442 F. Supp. 168, 172-73 (N.D. Ill. 1977) no exemptions from disclosure); *Dunbar* v. *Toia*, 61 App. Div. 2d 914, 403 N.Y.S.2d 4 (1st Dep't), *aff'd*, 45 N.Y.2d 764, 380 N.E.2d 321, 408 N.Y.S.2d 495 (1978) (same). Moreover, an exemption for medically contraindicated information would tend to frustrate the purpose of the requirement of disclosure. As appellees point out, very often the medically contraindicated information will be the information most useful to a patient in contesting an adverse Utilization Review Committee decision. If the information indicates a condition or prognosis unfavorable enough to upset the patient severely, perhaps it also is unfavorable enough to provide the patient with a defense against the Committee's determination that he does not require a continuation of the level of medical care that he has been receiving.

Appellant's brief on appeal argues that failure to disclose to the patient medically contraindicated information would not make the information unavailable to the patient at the fair hearing. Appellants wish to "emphasize[] that the information withheld from the patient himself will be disclosed to the patient's representative or relative." But, as appellees point out, a substantial proportion of health care facility patients may not have a representative or relative sufficiently concerned about their well-being to seek out and present at the fair hearing the withheld information. The appropriate position lies in between: if the state or local agency will guarantee that it will provide representation to the patient from whom it seeks to withhold medically contraindicated information and that it will disclose to the representative this information, then the information may be withheld from the patient.

Absent such a guarantee the preliminary injunction must be upheld. Appellants may, of course, apply to the district court to modify the injunction when they are ready, willing, and able to provide the required representation.

Judgment affirmed.

LUMBARD, *Circuit Judge* (concurring in part and dissenting in part):

I dissent from so much of Judge Oakes' opinion as requires the continued maintenance of the dual system of notification which the state officials in charge have found to be "cumbersome to administer, inefficient, and confusing to the patient." I would hold that the appellants' decision to implement a single notification system in place of the older dual notification system is within the realm of discretion allowed to them by the relevant regulations.

The majority, however, has concluded that "regardless of how we may feel about seemingly unnecessary bureaucratic red tape, the HEW regulations clearly require the state or local agency to provide the notice of transfer or reduction or termination of benefits, 45 C.F.R. § 205.10(a)(4)(i), and further seem to preclude delegation of the responsibility. *Id.* § 205.100(b)(1)."

Although the majority has not thought it necessary to quote from the regulations themselves, an examination of their text will indicate why my reading of these regulations differs so markedly from their reading.

45 C.F.R. § 205.10(a)(4)(i) provides that:

> A State [Medicaid] plan shall provide for a system of hearings under which . . . The single State agency responsible for the program shall be responsible for fulfillment of hearing provisions. . . . In cases of intended action to discontinue, terminate, suspend, or re-

> duce assistance . . . the State or local agency shall give timely and adequate notice. . . .

45 C.F.R. § 205.100(b) provides that:

> The State agency will not delegate to other than its own officials its authority for exercising administrative discretion in the administration of supervision of the plan including the issuance of policies, rules, and regulations on program matters. . . . In the event that any services are performed for the single State agency by other State or local agencies, such agencies and offices must not have authority to review, change, or disapprove any administrative decision of the single State agency, or otherwise substitute their judgment for that of the agency as to the application of policies, rules, and regulations promulgated by the State agency.

Read in their entirety, these provisions of the C.F.R. carry a plain meaning. § 205.10(a)(4)(i) simply provides that the state agency is ultimately "responsible" for giving "timing and adequate notice. . . ." If this choice of words carries an implicit prohibition against delegation of duties even where the state agency retains ultimate responsibility to ensure that those duties are carried out properly, I fail to see it. In any event, § 205.100(b) clearly provides for the delegation of all duties imposed under the plan except for those functions which necessarily involve "discretion" or "supervision" such as would be involved in the "issuance of policies, rules, and regulations on program matters. . . ." The regulation explicitly permits the delegation of agency functions to other State or local agencies and offices, such as the Utilization Review Committee (URC), provided that these delegates have no authority to "review, change, or disapprove" decisions as to the application of the rules and regulations and as to the determination of policy decisions

generally. The delegates cannot "substitute their judgment" for the judgment of those responsible for running the program. Thus the regulations make the familiar distinction between discretionary, managerial, and policy-making tasks, which clearly cannot be delegated, and ministerial tasks, involving little or no exercise of discretionary judgment, which just as clearly can be delegated.

The issue before the court is whether the URC or the state agency will send a printed form to the Medicaid recipient advising him of his due process rights. Since the form must be sent whenever there is a reduction or termination of benefits, there is no discretionary or policy-making judgment involved in deciding when to send the form. And since all that is required is to place the form in an envelope and mail it, no discretionary or policy-making judgment is required in deciding how to send the form. Indeed, sending out these printed forms appears to be one of the most paradigmatically ministerial—and therefore delegable—tasks imaginable. If mailing forms cannot be delegated, I am hard put to think of what can be. Yet the reasoning of the majority opinion might be read to suggest that not only the placing of the forms in the envelopes must be carried out by agency officials, but that these officials must hand deliver each notice in person, rather than delegating the purely ministerial task of delivery to the United States Post Office.

That appellants have not, as the majority notes, cited any "authority for allowing a private party such as the health care facility to provide the notice required by due process before the State can reduce public assistance benefits" cannot require a different result. First, the absence of authority, to the degree it exists, springs from the utter futility of challenging delegation of such a purely ministerial function. Second, the URC, which the state officials would like to entrust with the ministerial task of providing

notice, is not a "private party [like] the health care facility," but rather, a public agency, whose establishment is required as a condition of participation in the Medicaid program, and which is given discretionary as well as notice responsibilities of its own. See 42 C.F.R. § 450.19(a)(3)(ix)(F). To prohibit a public agency with discretionary and managerial responsibilities from carrying out ministerial tasks at the direction of the state agency of which it is a part would be anomalous indeed. The plain meaning of the regulations cannot support such a result.

Moving beyond the regulations, I believe that there are other equally important reasons for reversing the district court's requirement that the dual notification system be maintained. First, the district court did not give sufficient deference to the determination of the state agencies that the dual notification system was "cumbersome to administer, inefficient and confusing to the patient," and that the single notification system, by contrast, "would benefit the patient and help streamline the complex network of Medicaid regulations." In addition to saving the extra expense of a duplicative system, the single notification system works to the patient's advantage by advising him simultaneously of both the URC decision and of his right to challenge that decision. Although some patients will not receive notice under either system so long as it is administered by fallible human beings, that is no reason for preferring the judgment of the district court to the judgment of state officials

who are entrusted with running these programs, who are intimately acquainted with the problems involved, and whose duty and interest is to see the program run smoothly. Where, as here, such officials make changes in the program within the realm of the discretion permitted to them under the regulations, their decisions are entitled to considerable deference by the federal judiciary.

Second, I believe that private plaintiffs who have not exhausted their administrative remedies bear an especially heavy burden in seeking to have a federal court upset a carefully considered state agency decision, particularly when they cannot refer to even one regulation prohibiting that decision. The federal courts are not ombudsmen. Plaintiffs should have brought their complaint in the first instance to HEW which is charged with administering the Medicaid program and which presumably has more expertise in this area than federal judges. Indeed, plaintiffs have not even bothered to find out what HEW's position on this matter is. Certainly we should be aware of HEW's position before we hazard a decision which may interfere with a complicated regulatory scheme. *Burford* v. *Sun Oil Co.*, 319 U.S. 315 (1943). If HEW is not satisfied with the manner in which the state is carrying out the program it has the duty and the authority to take the necessary action.

Deposition of Anthony J. Maddaloni (Excerpts)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

Two World Trade Center
New York, New York

October 26, 1978
2:00 P.M.

Deposition of ANTHONY J. MADDALONI, taken by the Plaintiffs, pursuant to Notice dated October 19, 1978.

[2] [Appearances omitted in printing.]

* * *

[3] ANTHONY J. MADDALONI, having been first duly sworn by a Notary Public of the State of New York, was examined and testified as follows:

Examination by Mr. Gassel:

Q. Would you state your full name, please. A. Anthony J. Maddaloni.

* * *

[4] Q. By whom are you employed? A. New York State Department of Health, Office of Health Systems Management.

Q. How long have you been at the Department? A. About two years, four months.

Q. What did you do before that? A. I was a business manager in a nursing home.

Q. Where was that? A. In Schenectady, New York.

Deposition of Anthony J. Maddaloni

Q. What is your job title? A. Associate Medical Care Administrator.

Q. Stripped of jargon, what do your duties entail? A. Responsible for coordinating and administrating all of the medical care programs under the Medicaid program.

Q. Whom do you supervise in that respect? A. A number of health professionals, administrators that deal with PMR's, periodic medical reviews, IPR's, independent professional reviews, the utilization review functions, DMS1's and the over-all Medicaid long-term care programs.

* * *

[10] Q. Mr. Maddaloni, you have been giving your answers in numbers of beds rather than patients. What is the over-all vacancy rate in New York, the average? A. I would imagine it would fluctuate. The Health Plan Commission would be responsible for tabulating vacancy rates.

Q. Is your information that the occupany rate is over 95 per cent generally throughout the state? A. The last figure that was presented to me was 93 per cent upstate and 91 per cent in the downstate area.

Mr. Kay: Are we talking now about SNF's, HRF's or both?

The Witness: We are talking about both.

Mr. Kay: The combined figure?

The Witness: Right.

* * *

[35] Q. What is the purpose of PMR then? A. The PMR and the IPR are Federally-mandated reviews to insure the quality of care, the accuracy or appropriateness of placement and whether or not the needs of the individuals within the nursing homes are being met.

Examination by Mr. Robert:

Q. The PMR is to set a quality control system [36] as to whether the medical records are accurate; is that cor-

rect? A. It is to determine whether the medical records accurately reflect the patient. However, it is more importantly a hands-on review of the patient to determine the care that they need is being received.

It is a quality insurance on care, not a quality insurance on how do you complete your medical records. The surveys would review the over-all operations and structure of the facility to determine that aspect.

Q. Is that because the provider himself has a higher error factor than what the government would like? Why are we monitoring these providers? Are they making mistakes? A. The Federal regulations require that for New York State to receive Federal financial participation, that we perform periodic medical reviews and independent professional reviews within RHCF settings. It is to determine and to insure that quality care is provided to patients. It is the same type of review that will be performed in hospitals by the JCAH to insure that that particular component—

Q. Is there any expectation that the provider is making mistakes? [37] A. No, I don't believe that that is the expectation. I think, like any regulation, you insure that certain things occur that are mandated in regulations, that you cannot just take it for granted, just as you could not take for granted that every driver would enforce a 55-mile limitation.

(Brief recess.)

By Mr. Gassel:

Q. Is your particular division, Mr. Maddaloni, responsible for implementation, supervision of the DMS1, how it is implemented by the facilities? A. Yes, we are responsible for surveying and monitoring the over-all utilization review program.

Q. And you were the people who put it out, put out the memoranda which implemented the system? A. Well, we, meaning the Office of Health Systems Management, reorganized from the time that the initial form was completed. However, the components, the units, are essentially the same.

* * *

[48] By Mr. Gassel:

Q. Have you made any cost benefit studies on the use of the DMS1 or the operation of utilization review to determine whether it is cost efficient? A. No, I don't know of any reports or studies that have come out of my office. That is not to say that somewhere in the Department they may not exist. The UR process is a Federally-mandated program, so whether or not we felt it was efficient or not would not preclude us from endorsing a Federally-mandated program.

Q. Well, there are administrative alternatives available to you, restructuring the system or going to a multilevel or some system or something like that. Has anybody done a cost benefit of those? A. Even with, say, a multilevel facility, a patient's condition would still not preclude the need for a utilization review committee.

Q. Have you determined how many patients, as a result of going through this process, are actually as a rule transferred to a lesser cost care and therefore financially benefit the state? A. There is really no documentation, as I said [49] earlier, to tell us how many patients moved because of the UR.

They can move by way of their attending physician saying, "I want my patient here to go from the skilled nursing to the health related, because it would be better for him."

It doesn't go through the UR Committee's functions.

Q. Have you done any follow-ups on patients who have been moved to a different level of care as a result of this process? Any follow-up of patients who have been transferred to see if patients are being transferred as a result of this process? A. Well, if patients were being transferred for any reason, there would be a back-up in the system sooner or later. As far as any studies to say what happens to a patient after—

Q. I am sorry, I want to make sure we are talking about the same thing.

When I said transferred, I meant transferred to other levels of care, and I sense that you were using it, correct me if I am wrong, in the larger sense you used it before, including, say, a trip to the hospital and so forth or discharge home.

[50] A. You are just talking about, we'll say, internal or even external transfers within the RHCF segment? A. Or from a health related facility to a domicile related facility. To a lesser cost care.

Have you done any follow-up of either the number of patients transferred as a result of this utilization review or what has happened to those patients, how many of them ended up back in a hospital within X period of time and how many of them died?

Mr. Kay: Let's take one at a time.

A. As I indicated before, we receive statistics as far as how many patients go to certain levels of care. As far as how many times we are counting the same patient, I couldn't tell you.

Q. That is not to say that there aren't studies that exist, because the Health Systems agencies do perform certain studies like that to determine occupancy and certification of needs within a certain—

Q. But the Department hasn't followed up on any patients longitudinally, followed through to see how many

times the same patient was being transferred. Are we getting patients who are going back and forth, or is it one patient going once and staying there? A. With our data system, we will be able to [51] track a patient to see if he goes from the SNF to the HRF and back immediately because of some breakdown or if he goes to the HRF out of the system and again comes back. We would be able to determine that.

* * *

[53] By Mr. Gassel:

Q. Is it a reasonable assumption that there are a number of patients in the long-term care system who do not have either family or close friends who are looking after their affairs? A. No, that is not an accurate assumption that can be made, that people who go into nursing homes are necessarily abandoned.

Q. But it is true that there are probably a percentage of them?

Mr. Kay: Do you know?

A. I can't tell you if there are ten per cent, five per cent, one per cent. I would assume—

Mr. Kay: Don't assume.

Mr. Gassel: He is a health care professional. He can make assumptions along those lines.

Mr. Kay: If you can make an educated assumption.

Mr. Gassel: He does work in the field.

[54] A. It's an assumption that can be made just on the general population that you may not have any kin, may not have any close friends, so you can carry that proportion throughout any type of projection.

Q. Are the elderly less likely to have kin than you and I? A. I don't believe so.

Q. I mean, when people get old, they die off. A. Yes, but when people get old, they usually leave the ones that take care of them.

Mr. Kay: Off the record.

(Discussion off the record.)

Q. I am going to make an assumption—tell me if it is an invalid assumption—that there are a number of persons in long-term care facilities, probably a significant percentage, who are either senile or otherwise not capable of handling affairs like utilization review themselves, without assistance.

Is that an accurate assumption?

A. It would depend on what you are calling senile. If you are indicating that there is a certain percentage of individuals within the RHCF setting that have received some type of cerebral vascular accident or have arteriosclerotic heart disease that would [55] impair their capacity to understand, we do know that there are a number of patients that have had that as a diagnosis.

As far as whether or not they were cured of that particular diagnosis, I couldn't tell you.

Mr. Robert: Is there anything in the system to flag those types of people so if an adverse decision is made by the utilization review, the system can be assured that a representative is watching over the interests of that flagged type of person?

The Witness: We would not flag that type of patient with that diagnosis, because they are found throughout the system. The are found throughout society. We have found through our study that diagnosis does not predict an individual's level of

care. He may be at home with the same diagnosis that he would be in the hospital with. It depends on the intensity and the current nature of his diagnosis.

By Mr. Gassel:

Q. Is it true that there is no system which would identify and flag those individuals who lack mental or physical capacity and/or lack appropriate next of kin [56] or next friend to insure that somebody is looking out for their interest in the case of an adverse utilization review determination? A. Within our regulations, we require that in any type of admissions process there be identified those individuals who would be responsible or who would be contacted in cases of emergency.

If there is no one to handle an individual's financial or discharge planning, they should be contacting a local district.

Q. What kind? A. The local Social Services district.

Q. So they are supposed to take care of those needs? A. They are supposed to help those that are in need of some type of welfare.

Q. Do you know that in fact Social Service districts perform that function for patients in those facilities? A. I can say only through my own personal experience that yes, they do. Through the nursing home that I worked for, we had individuals who had as their conservator or as their legal guardian, the Commissioner of Social Services.

[57] Q. But you had experience in a facility. Isn't it true that only the smallest percentage, very few individuals, have either legal guardians or conservators? A. In my experience in our facility, I would not say it was an overwhelming percentage, but that's basically because the other patients would have had some type of representation through their family or friends.

* * *

[67] By Mr. Robert:

Q. Could you explain the difference between when you need the certification of two utilization review doctors as opposed to only one utilization review doctor? A. There is the case of whether a utilization review physician, upon reviewing the patient's medical condition as presented to him through the committee, decides that the individual needs an alternate level of care; that is, a level of care other than the one that they are currently placed in. And the individual's attending physician does not concur with the UR physician's [68] determination.

* * *

Q. Assuming that a personal physician says that his patient should remain at the facility and the utilization review doctor says he should not, what is the process of notification from the utilization to the personnel? A. You mean—

Q. The attending physician says, "My patient should stay." The utilization physician says, "No, you are wrong." A. There would be no notification until the second utilization review physician either concurred with the UR physician or the attending physician.

* * *

[69] By Mr. Gassel:

Q. Mr. Maddaloni, on this attending physician business, are the attending physicians always house staff or can they come from the outside? A. Yes, they can be private practicing physicians and do not have to be affiliated with the facility.

Q. Do a significant number of facilities in the State operate on that basis with outside staff? A. I couldn't give you an accurate reflection. We are trying to establish rates so that they include service of the physician within it.

That does not mean that they in turn cannot seek an alternate group of doctors to provide the service.

Q. Are you aware of the facilities that do not have in-house staff doctors? A. Oh, yes.

[70] Q. In those cases, the attending physician might come by just once a month or so, might only be in the nursing home once a month or twice a month or infrequently; is that correct? A. Under Federal and State regulations, the attending physician would have to see the patient at least monthly. And if he is going to see the individual less than every thirty days, he has to document in a plan of care the reason he is not seeing him more often.

Q. He has to be in the home at least that often, but it might also mean that he is not there on a day-to-day basis? A. That's correct.

Q. He might be there no more than once a month, twice a month, and see a number of patients that day; is that correct? A. That's correct. It would be dependent on his patient's condition.

Q. Is the attending physician required to attend the utilization review committeee meetings? A. No.

* * *

[94] Q. I would like to ask some questions about the PMR and IPR.

There is a Federal requirement that the state do something called utilization control as I understand it which is to supervise utilization review and monitor how it is conducted in the various facilities.

Is PMR and IPR the mechanism that the Department uses to perform that utilization control? A. That is part of the utilization control, yes.

Q. What else is there? A. There would be the DMS1 data system, when developed.

Q. That is in the future? A. Yes. The MMIS system, when developed. But currently, our best control on utilization is the PMR's and the surveys.

[95] Q. Do the surveys check on individual eligibility and individual placement? A. As far as medical reviews, no.

Q. So it is only the PMR and the IPR? A. That is correct.

Q. Do they fill out a form on each patient? A. No, they fill out a form which checks off a variety of medical information that has to be in the form. In other words, are the doctor's medical notes available and are they documented appropriately. It does not assess the patient as far as saying does this person ambulate, does he not ambulate.

It looks at the individual and the record as far as saying are the records and the plan of care being carried out, is the medical record appropriate to reflect the care needs of the individual.

Q. The utilization review evaluates patients against certain criteria which the State defines. Does the PMR and the IPR evaluate the patient individually and does it evaluate against the same criteria, namely, the DMS1 and the scoring system? A. It would not utilize them, because it has to actually give a full chart review and a one hundred percent patient review. It has to check each patient [96] to determine that there is appropriate care being provided to the patient and that his physical condition is not deteriorating in any way where his needs are not being met.

Q. And the PMR makes a medical evaluation of the patient's needs? A. That is correct.

Q. Against what criteria? A. Against Federal and State criteria.

Q. But the Federal and State criteria are defined in Memo 77-9 and 77-10, aren't they? A. It depends on the specific review. Now, we are talking about an over-all review. The criteria that is presented on the DMS1 form is not asking whether or not the nurse's notes are contained in the medical record. This is something that the PMR would be asking.

So it goes beyond just the DMS1, as I indicated. It asks for more than just what the regulations that are appropriate for DMS1 are concerned with.

It has incorporated the information that we would have on the DMS1, yes. That type of information is incorporated in the review.

It does not take the DMS1 form, to take the patient and review the DMS1 form. It takes another [97] form and determines whether or not the medical record and the patient are reflective of one another.

Q. Are the criteria for that form identical as for the DMS1? A. No. That's because they are serving another purpose. One is asking about the appropriateness of the medical record in its entirety and the quality of the care being provided to the individual. The other one is assessing the individual's condition.

Mr. Robert: If the PMR indicated that the medical record did not reflect in it the physical nature of the patient, what would the validity of the DMS1 be that scored itself from the medical records that have now been stated not to coincide with the actual medical needs of the patient?

The Witness: We would be making an assumption that the DMS1 was only based on the medical record. The DMS1 is part of the medical record and would therefore be in error as part of the

medical record if in fact the DMS1 did not reflect the patient's medical condition.

That is an assumption that would have to be made, since the DMS1 would be just assessment [98] by reviewing the patient's condition and making an observation of his condition without having to constantly refer to the chart.

Q. If one were to see a PMR report for two facilities identifying the same PMR team leader, can we assume that it is the same team or can one leader head two teams? A. Well, once again it's going to depend on the area office, how they structure themselves, how large they are. Certain team leaders have a number of different teams.

Well, it's one team, but a number of different reviewers, and they will go in as a team to one facility and may replace a nurse with another social worker and go into the other. So that the individuals are not the same, but they are under one team.

Q. Could one team leader be doing a PMR on two facilities simultaneously heading up two different teams; or is that not the way it works? A. Then they would be team coordinators, just coordinating the review.

Q. Does that happen? A. I couldn't state with any accuracy.

Q. On a PMR report, when it says date of [99] completion or something like that, is that the last date they were on site or could that be a date later? A. No, that is the last date they were on site. That's the date of the last chart review.

Q. So if one were to see an October 10th date that one PMR was completed and a second PMR was completed by the same team on October 15, would you assume that the second one was done between the 10th and the 15th? A.

No, it could be that there was another nurse and social worker or another group of reviewers in that particular facility at the same time another team was in another facility.

Q. So they were going on simultaneously? A. Yes, but there are two different entities here.

Q. But even if they were identified as the same team leader? A. Once again, it could be a team coordinator that you are identifying rather than a team leader and, in effect, you have got two review groups and one is in one facility and one is in another.

By Mr. Robert:

Q. What is the role of the local medical [100] director? A. The local medical director is either a state or county employee, depending on whether it's a contract county or whether the state is making the reviews. He is responsible for making determinations as to the appropriateness for paying Medicaid claims.

He will review anything from a physician's request for some type of orthopedic device or a placement of an individual in a particular facility.

Q. As to the UR process, can the local medical director reverse a UR decision? A. He will not reverse the decision. He would make a determination for Medicaid purposes that we would not pay, given the information that is available.

Q. If the utilization review decision was not to transfer a patient, could the local medical director make a decision not to pay that facility for that patient? A. Under our regulations, Social Services regulations, that would be the case.

Q. What criteria would the medical director use? A. He would be utilizing the same information. Or he has access to the same information that the UR Committee would; that is, the DMS1 form and any other pertinent in-

formation that would justify or support the [101] placement.

Q. So the utilization review team has the information before it and certifies that the patient should not be transferred. I assume that is then forwarded to the local medical director and he has the authority to not pay the Medicaid payment to that facility based on the UR decision? A. The local medical director is certifying patients. He is not necessarily stopping it, because it hasn't started yet.

A phsyician is required to certify that the standards, if below 180 or 60, to SNF and HRF respectively, do not adequately reflect the individual's placement needs.

The local medical director would then review that certification and any justification for that decision and make a determination as to whether or not he will implement the Medicaid payment process.

Q. Could you explain the distinction between a local medical director reversing a UR and a local medical director certifying that he will not certify Medicaid payments? A. For him to reverse the determination of the utilization review—well, I believe under Chapter 77, [102] he can actually reverse the determination. However, in the way we have structured our assessment system, he does not get involved in the UR functioning as a committee.

He only gets involved in the placement certification, not the continued stay. We take the continued stay assessment to be what the UR Committee determines.

He may ask for samples of certain reviews if he feels that there is a problem and he wants to review the continued need for medical payment.

Q. Are there any definitions or instructions in the entire series regarding the capability of adult home or domiciliary care facilities? Are there any definitions or descriptions of what the capabilities are? A. In what regulations?

Q. In any of the health memoranda. A. No, the domiciliary are not under UR monitoring or jurisdiction; they are under the Department of Social Services.

• • •

[103] By Mr. Gassel:

Q. Is there a system of monitoring the medical [104] records, the quality and completeness of medical records, in a facility other than the PMR and IPR processes you describe earlier? I don't want to repeat it if it is as you described it. Is the way that the Department monitors the quality and completeness of medical records in a facility through IPR and PMR? A. That's right. And the surveillance process would also monitor the medical records.

March 5, 1979 Pretrial Order (Excerpts)

UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF NEW YORK

* * *

[Title omitted in printing.]

[Appearances omitted in printing.]

A. *Nature of Action and Proceedings*

This is a class action suit brought on behalf of all Medicaid-eligible residents of nursing facilities—skilled nursing facilities (SNF's) and health-related facilities (HRF's)—in the State of New York challenging on procedural and substantive grounds the validity, under the Fourteenth Amendment to the United States Constitution, Title XIX of the federal Social Security Act (42 U.S.C. § 1396 *et seq.*), applicable regulations of the United States Department of Health, Education and Welfare (HEW), and applicable laws of New York State, of the utilization review and fair hearing process administered by the New York State Departments of Social Services and Health, insofar as it causes patients to be transferred or discharged from their current facilities or level-of-care, or threatened with such transfer or discharge.

In January 1978 this Court certified this action as a class action and issued a preliminary injunction on behalf of the plaintiff class requiring the defendants or the state or local agency to provide every facility patient, following an adverse utilization review (UR) determination that the

patient no longer needs his current level-of-care, with (1) timely and adequate written notice of proposed agency action to adjust Medicaid benefits which is provided by the State or local agency, fully complies with the requirements of 45 C.F.R. § 205.10(a)(4)(i)(B), and includes a detailed written statement of the specific changed medical or other circumstances justifying the UR determination, and (2) with unencumbered access prior to and during the fair hearing to all relevant documents and medical records, including all such documents and records which are located at the nursing facility and which contain so-called "medically contraindicated" information. By decision issued January 16, 1979 the Second Circuit Court of Appeals affirmed that preliminary injunction, insofar as appealed from by defendants on the issues of the State or local agency's obligation to provide the notice and the patient's right of access to medically contraindicated information.

Earlier, on June 30, 1978, on plaintiff's motion for partial summary judgment, this Court granted a declaratory judgment, but not injunctive relief, that the Department of Health Hospital Memoranda establishing the numerical scoring system used in filling out the long-term care placement form DMS-1 are legally invalid for noncompliance with the rulemaking requirements of the New York State Administrative Procedure Act. 456 F. Supp. 653. Plaintiffs are now preparing for a final trial on the merits of their claims.

B. *Nature of Parties*

The plaintiffs are a class composed of all residents of skilled nursing and health related nursing facilities in New York State who are recipients of Medicaid benefits. The defendants are the Commissioner of the New York State Department of Social Services and the Commissioner

of the New York State Department of Health. The State Department of Social Services is the "single State agency" responsible for administering the Medicaid program in New York State and insuring full compliance with all the Federal requirements and rights set forth in Title XIX of the Social Security Act and implementing HEW regulations, and is particularly responsible for providing agency and fair hearing review of adverse UR determinations. The State Department of Health is responsible for licensing nursing facilities in New York State, for establishing reimbursement policies, for overseeing and reviewing patient placement, and for administering and monitoring the utilization review process for assessing the continued stay needs of facility patients.

C. *Jurisdiction*

As this Court has earlier determined, subject-matter jurisdiction over this suit is conferred upon the Court by 28 U.S.C. §§ 1331(a) and 1343(3).

D. *Relief Requested*

Plaintiffs seek a declaratory judgment that they have the following rights, with corresponding injunctive relief, requiring defendants, and their successors and agents, to secure those rights for plaintiffs:

I. There shall be no involuntary transfers of nursing facility patients in the State of New York, to a different level of care or facility, unless and until such time as defendants:

A. provide plaintiff with all the procedural and substantive safeguards which are set forth in II below and to which plaintiffs are entitled by the Constitution and federal and state law, *and*

B. with regard to patients who do not already reside in facilities providing at least skilled nursing and health related care, complete all steps necessary to minimize the impact of any involuntary transfer or threat thereof through alternative administrative systems which include, but are not limited to:

(i) maximizing the number of facilities that provide at least SNF and HRF levels-of-care by requiring all single-level SNF or HRF facilities capable of doing so to reclassify a portion of their beds to the other level of care, over a phase-in period; or

(ii) adopting an effectively equivalent system such as a single all-inclusive level-of-care, or

(iii) having beds whose classification can be shifted between "levels-of-care" depending on the needs of the occupant, or

(iv) a combination thereof; *and*

(v) modifying the present "alternate care" provisions (which currently require that a Medicaid patient requiring alternate care to accept the first available bed within 50 miles) to enable any patient who so desires to receive such alternate care within the same facility.

II. *Required Procedural and Substantive Safeguards*

A. Every patient who is the subject of an adverse UR decision must be provided, at defendants' expense, with a trained representative from the point of initial UR notice to the patient, and with counsel, also at defendants' expense, to represent him during the course of any hearing or other review proceedings requested to

appeal in adverse determinations, if such counsel is not otherwise available.

B. Following an adverse UR determination, the state or local Department of Social Services or Health must provide the affected patient with timely and adequate notice of proposed agency action to adjust Medicaid benefits that fully complies with the requirements of 45 C.F.R. § 205.10(a)(4)(ii)(B) and includes a detailed written statement of the specific changed medical conditions or other circumstances of the patient which purportedly justify the adverse UR determination.

C. Every affected patient must have a fully adequate opportunity, prior to and during the fair hearing, to review an adverse UR determination, to have unencumbered access to, and to review and copy without charge, the contents of that patient's case file, and all documents and records to be used against the patient at the hearing, all documents, medical or otherwise, which were considered or relied on by the Utilization Review Committee (URC), and all medical documents and records concerning the patient which are located at the nursing facility where the patient resides, including all so-called "medically contraindicated information" contained in any such documents or records.

D. The URC person(s) who make(s) the adverse determination must personally examine the affected patient, and must be present at the hearing and there present evidence sufficient to establish a *prima facie* case to sustain the correctness of that determination.

E. The *prima facie* showing which must be made at the fair hearing in order to affirm an adverse UR determination must be made by clear and convincing proof of the following elements:

1. that the patient will not suffer consequential

harm, either physical or psychological, as a result of, e.g., physical relocation, dislocation from home, unfamiliar environment, separation from others, erroneous level-of-care decision, placement in an inappropriate facility, etc.;

2. that the proposed level-of-care is appropriate;

3. that the specific proposed placement will meet the patient's needs;

4. that all procedural and technical prerequisites of the UR process have been complied with, including:

(a) that the following persons signed the DMS-1 or other assessment instrument, indicating their recommended decision and the reasons for it;

(i) the RN who completed the instrument;

(ii) the UR "screener" who screened the case and initially determined that continued stay is inappropriate;

(iii) the UR doctor who made the initial UR finding;

(iv) the patient's attending physician to indicate that he has seen the initial finding and has had the opportunity to review it;

(v) two UR doctors who reviewed the attending physician's recommendation, if the latter presented additional or clarifying information concerning the need for continued stay or contested the adverse initial UR finding;

(b) that the UR physician(s) who made the determination examined the patient and made a notation that such examination was made;

(c) that the URC has considered in its initial review the reasons and plan for continued stay if the attending physician believes continued stay is necessary;

(d) that a transfer plan identifying and describing the specific proposed transferee facility or location appropriate to the patient's medical and psycho-social needs was developed prior to each adverse UR determination, was considered by the URC and was incorporated in its determination;

(e) that, in the case of a patient initially admitted to the facility prior to March 1, 1977 (regardless of intermittent hospitalization or other short-term absence), the assessment instrument was not scored and the numerical criteria were not applied;

(f) that the DMS-1 form contains no unrefuted answers to the non-numerically weighted questions on the DMS-1 form (e.g., Question 3D, 3E, 3F, 9A-C, 10), which would be inconsistent with the recommended determination;

(g) that the review process and assessment instruments used considered and assessed all relevant psycho-social factors;

(h) in the case of a transfer to a level-of-care below that of HRF, that the patient requires no care or services beyond room and board;

(i) that all procedural requirements specified in paragraphs A-C above have been satisfied.

F. No adverse UR determination may be made or implemented which would not meet the requirements of a *prima facie* case described in paragraph E above.

G. The defendants may not render a fair hearing decision affirming an adverse UR determination. Unless a transcript and all exhibits are reviewed and adequately considered by the reviewing agent, and further, the reversal of a favorable recommendation of the hearing officer cannot be based on consideration of a credibity issue.

H. The state or local agency must independently review and reject adverse UR determinations for at least facial defects (including, but not limited to, items identified in paragraphs E(4)(a), E(4)(b), E(4)(e), E(4)(f), and E(4)(i), above) and for defects in the statement of reasons included in paragraph B above, and must so certify, before agency notice may be sent to the patient.

I. Doctors who serve on the UR committee of a facility may not also be the attending physician for any patients in the faciltiy or in any other facility owned or operated under the same management, ownership or auspices.

J. The right to a prior hearing incorporating the above procedural safeguards shall be guaranteed as well in cases of a proposed transfer arising from a determination.

(a) by the URC that the patient should be transferred to a higher level of care; or

(b) by the facility or its agents.

K. All state regulations, standards, and procedures governing the utilization review and fair hearing processes for determining the appropriate level of care for a nursing facility patient shall be promulgated in accordance with the State Administrative Procedure Act, and further shall conform in all respects with applicable federal statutory and regulatory provisions.

E. *Factual Issues Underlying Plaintiff's Claims for Relief*

Plaintiffs—Generally

1. Whether a substantial proportion of the plaintiff class is elderly, infirm, frail, dependent, confused, or has a poor prognosis, or a combination thereof.

2. Whether a substantial proportion of plaintiffs are essentially helpless because of physical or mental impairment.

3. Whether, as a practical matter, the overwhelming majority of plaintiffs are confined to nursing homes without choice, for want of a viable alternative.

Defendants' System of Utilization Review and Fair Hearing Appeals—Generally

4. Whether defendants' DMS-1 form and numerical scoring system are inadequate *per se* and/or as employed in the utilization review process.

5. Whether defendants' utilization review procedures are inadequate *per se* and/or as carried out in SNF's and HRF's in New York State.

6. Whether defendants' system of notice and fair hearing review of decisions which recommend transfer of nursing home patients to other facilities or other levels of care, is inadequate *per se* and/or as applied.

7. Whether defendants have failed to correct the inadequacies, both inherent and as implemented in the DMS-1 form and numerical scoring system, utilization review procedures, and system of notice and fair hearing review.

8. Whether, and to what extent, in the context of defendants' present system of nursing home classification and reimbursement, defendants' DMS-1/UR system:

(a) causes harm or risk of harm to Medicaid patients in SNF's and HRF's flowing from:

(i) anxiety or trauma

(ii) deprivation of care or services

(iii) eviction from place of residence or other dislocation from environment

(v) [iv] interference with relationships with friends, family, staff or others

(b) actually serves legitimate interests of defendants.

9. Whether the harm to plaintiffs outweighs the interests of defendants actually served by the present system.

10. The extent to which alternatives and/or modifications are possible which defendants have failed to implement which:

(a) would be less restrictive and harmful to plaintiffs than the present system

(b) would serve defendants' interests no less well than the present system.

11. Whether defendants have adequately or effectively controlled the functioning of the UR and fair hearing process.

12. Whether defendants have provided sufficient safeguards to assure that eligibility is determined and care provided in a manner which is consistent with (a) simplicity of administration and/or (b) the best interests of plaintiffs.

13. Whether defendants' present system of UR and fair hearings, in conjunction with defendants' present system of nursing home facilities and reimbursement, operates in a manner consistent with . . . simplicity of administration and/or the best interests of plaintiffs.

14. Whether it is possible to effectively balance the protectable interests of plaintiffs and defendants without:

(a) halting the involuntary transfer of nursing home patients to other facilities or levels of care, and

(b) implementing the procedural and substantive safeguards outlined in DII above, to the extent involuntary transfer is permitted at all, and

(c) modifying the level-of-care classification and/or method of Medicaid reimbursement as outlined in DI above, to the extent that patients residing in, single level facilities are threatened with involuntary transfer.

Notice

15. To the extent that the issue of whether notification of due process rights must be provided by the state or local agency or may be delegated to the facility, is not purely a matter of law, whether

(a) the notification procedures required by the preliminary injunction are unduly cumbersome, inefficient or confusing,

(b) a notification system which relies on facilities would adequately protect patients or be dependable,

Pretrial Order

Representative and Counsel

16. Whether a substantial proportion of plaintiffs' are unable to protect their rights and interests upon receipt of an adverse UR determination.

17. Whether a substantial proportion of those persons have no one to reliably protect those interests.

18. Whether defendants have an effective means of

(a) identifying who such persons are, and

(b) insuring that their interests are reasonably protected by appropriate advocacy assistance and, when necessary, legal counsel.

Reliability of UR and Fair Hearing Decisions

19. To what extent UR determinations and fair hearing decisions are unreliable and prove to error if the UR committee person(s) who make(s) the adverse determination did not personally examine the patient affected and present evidence at the hearing, if one is requested, sufficient to substantiate the determination.

20. To what extent UR determinations and fair hearing decisions are unreliable and prove to error without a showing by clear and convincing evidence that:

(a) the patient will not suffer consequential harm;

(b) the specific characteristics of the proposed placement, or, if necessary, the specific facility, were identified and will be appropriate to the patient's specific needs.

21. To what extent fair hearing decisions are unreliable and prove error if rendered without preparation of a

transcript of the hearing which is reviewed along with the exhibits, or if hearing officer recommendations favorable to the patient are reversed on issues of credibility.

22. To what extent UR determinations and fair hearing decisions are unreliable and prove to error if the state or local agency does not review and reject adverse UR determinations for at least facial defects before agency notice is sent to the patient.

23. To what extent UR determinations and fair hearing decisions are unreliable and prove to error if UR committee physicians also serve as attending physicians in the facility or one under the same management, ownership or auspices.

Attending Physicians

24. Whether patients attending physicians are afforded a meaningful and adequate opportunity to respond to the initial UR finding.

Specificity of Destination

25. Whether individual facilities have such unique characteristics and individual differences that a decision to involuntarily transfer a patient, which identifies the recommended destination only by its level-of-care, is inadequate.

Procedural and Technical Pre-requisites

26. Whether the procedural and technical pre-requisites of the UR and fair hearing processes are not complied with in a substantial proportion of cases and the fact of non-compliance is not detected or cured by the UR determination or fair hearing decision.

Local Agency Review

27. Whether the state or local agency adequately reviews and rejects adverse UR determinations for at least facial defects before notice is sent to the patient.

Non-UR Transfers And Tranfers To Higher Level

28. Whether, and to what extent, a prior fair hearing incorporating all procedural safeguards is useful in protecting patients in SNF's and HRF's from erroneous, arbitrary, punitive or retaliatory discharge, in cases of proposed transfer arising from a determination by

(a) the UR committee that the patient should be transferred to a higher level of care, or

(b) the facility or attending physician.

State Admin. Proc. Act and Supremacy Clause

29. Whether defendants' UR and fair hearing regulations, standards and procedures are properly promulgated in accordance with the New York State Administrative Procedure Act and the Supremacy Clause of the United States Constitution.

F. *Legal Issues Underlying Plaintiffs' Claims for Relief*

I. *No Involuntary Transfers*

Whether all involuntary transfers of nursing facility patients to other facilities or levels-of-care must be stopped (1) as the least restrictive alternative to the unwarranted and severe intrusion of the present system

upon the patients' constitutionally fundamental rights under the Fourteenth Amendment to procedural due process and to protection from harm and (2) in conformity with the requirement under the Social Security Act and the HEW regulations that the defendants maintain an effective system of utilization review, effectively monitor and control the operations of that system and administer the Medicaid program in the best interests of the patients consistent with considerations of simplicity of administration.

II.A *Right to Assigned Representative and Legal Counsel*

Whether the affected patient has the right under the Fourteenth Amendment's Due Process Clause to the provision of such representative and counsel at state expense, flowing from the heightened judicial solicitude to which plaintiff's class is entitled and the constitutionally protected patient interest in protection from harm and loss of life which is at stake, along with the Medicaid benefits and necessary medical care and services.

II.B *Notice Requirements*

Whether the provision of such notice by the State or local agency is required by HEW regulations and the Fourteenth Amendment's Due Process Clause, as earlier found by this Court and the Second Circuit in this case.

II.C *Pre-Hearing Access to Records*

Whether such patient access to all records and documents is required by HEW regulations and the Fourteenth Amendment's Due Process Clause, as earlier found by this Court and the Second Circuit in this case.

Pretrial Order

II.D *UR Doctor Examination of Patient and Presence at Hearing*

Whether HEW regulations, regulations of the New York State Commissioner of Social Services, principles of federal and New York State administrative law, and the Fourteenth Amendment's Due Process Clause require that the person who made the adverse UR decision affecting: (1) the patient's Medicaid benefits, (2) level of medical care and services, and (3) constitutional right to protection from harm must appear at the review hearing and present competent and reliable non-hearsay evidence sufficient to establish a *prima facie* case in support of that decision.

II.E *Prima Facie Case at Hearing*

Whether the initial decision-maker's *prima facie* case at the fair hearing in support of an adverse UR determination must include proof of the essential procedural and substantive requisites of a properly rendered UR determination under HEW regulations, the Constitution, and defendant's own procedures; and whether such proof must be by clear and convincing evidence, in light of (1) the fundamental constitutional interests at stake, (2) the probability of error, (3) the harm flowing from error, and (4) the heightened judicial solicitude to which members of plaintiffs' class are entitled.

II.F *All Adverse UR Determinations Must Meet Prima Facie Requirements*

Whether the Fourteenth Amendment's Due Process Clause, the Social Security Act, and New York State law permit an adverse UR determination to be made or implemented which could not, as a matter of law, establish a *prima facie* case at the fair hearing so as to justify

action based on that determination to transfer the patient and adjust his Medicaid benefits.

II.G *Review of Fair Hearing Transcript*

Whether the Fourteenth Amendment's Due Process Clause and New York State decisional law require the defendants to review and consider the transcript and exhibits of the hearing before rendering a fair hearing decision adverse to the patient and prohibit defendants from reversing a hearing officer recommended decision favorable to the patient on the basis of credibility issues.

II.H *Independent Agency Review*

Whether such State or local agency review before sending notice of intended agency action to adjust a patient's Medicaid benefits is required by the Fourteenth Amendment's Due Process Clause, the Social Security Act, HEW regulations, and New York State statutory and regulatory law.

II.I *Impartiality of UR Doctors*

Whether the inherent bias in favor of the facility's interest arising from the fact that the UR doctor is the attending physician for any patients in the same or a similarly controlled facility violates the substance or intent of the federal statutory and regulatory provisions regarding UR doctor impartiality and the Fourteenth Amendment's Due Process Clause.

II.J *Right to Prior Hearing in Cases of Facility-Initiated Transfers and UR Transfers to Higher Levels of Care*

Whether the patient has the right to an evidentiary hearing prior to such transfers, under New York State

regulatory and decisional law and the Fourteenth Amendment's Due Process Clause; whether the procedural protections of due process are triggered for such transfers by the existence (a) of state action inhering in the requirements of the Social Security Act, Hew regulations, and New York State law that defendants review these transfer decisions, in the extensive state regulation of the URC and the facility and the "symbiotic relationship" between the State and the URC and facility, and in the "state" or "public function" performed by the URC and facility; and (b) of the deprivation of patient interests protected by due process in the ultimate reduction of Medicaid benefits (transfer down), in the attendant transfer trauma and deprivation of the patient's constitutional right to protection from harm, and in the patient's right under HEW regulations to be free of a facility-initiated transfer except for limited, specific reasons.

II.K *Proper Promulgation and Content State Regulations and Procedures*

Whether all such regulations, standards, and procedures must be promulgated in accordance with the New York State Administrative Procedure Act, under the terms of the Act, New York State decisional law, and the earlier decision of this Court (456 F. Supp. 653), and must conform to federal law under the Supremacy Clause of the United States Constitution.

G. *Joint Statement of Facts*

The following is the parties' joint statement of facts. Statements of fact not otherwise identified have been stipulated as true by the parties. Plaintiffs' and defendants' respective versions of disputed facts are indented from the margin and identified in each case by the words *"Plaintiffs assert"* or *"Defendants assert"*.

Pretrial Order

I. *Nursing Home Patients And the Long Term Care System in New York—Generally*

1. Under New York law, nursing homes are known as Residential Health Care Facilities (RHCF's).

2. There are two levels of nursing home care: skilled nursing facility care ("SNF") and health related facility care ("HRF"). Under federal law and regulations HRF's are referred to as Intermediate Care Facilities ("ICF's").

3. SNF's and HRF's are licensed by the Department of Health and receive reimbursement under the Medicaid program.

4. There are approximately 95,000 nursing home beds in the State of New York, including approximately 68,000 SNF beds (70%) and 27,000—30,000 HRF beds (30%).

5. There are approximately 611 nursing homes in New York State, including approximately 291 single level SNF's (48%), 290 combination SNF-HRF (48%), and 30 single level HRF's (5%).

6. In addition to SNF's and HRF's (nursing homes), there is a system of adult homes (which are *not* nursing homes) in New York known as Residential Care Facilities for Adults ("RCFA's") or Domiciliary Care Facilities ("DCF's"). This is a placement level below the HRF level.

7. DCF's are licensed by the Department of Division of Adult Residential Care (DARC) of the Department of Social Services and receive reimbursement under the Supplemental Security Income (SSI) program.

8. DCF's are not medical facilities; they are not permitted to provide medical or nursing services, may not hire nurses

for the purpose of providing nursing services; and may not admit or retain a person in need of continuous nursing care. In some adult homes catering to SSI (Medicaid) recipients, mental hospital dischargees and alcoholics are mixed in with elderly residents.

9. *Defendants assert* that (a) a DCF resident could be in need of intermittent or occasional nursing service which could be provided by visiting nurse service or like provider. (b) it is possible for a DCF operator to have persons with nursing credentials on staff; some do.

10. More than 90% of patients in SNF's and HRF's in New York State receive Medicaid benefits for the cost of their care.

11. When a patient is transferred from an SNF or HRF to another facility or another level of care, his/her Medicaid reimbursement rate is adjusted accordingly.

12. Medicaid reimbursement rates ordinarily are lower for HRFs than for SNFs and lower for DCFs than for either HRFs or SNFs. Accordingly when a patient is transferred to a lower level of care, there is a reduction in the patient's Medicaid reimbursement level.

13. *Plaintiffs assert that:*

(a) a substantial proportion of patients in SNF's and HRF's are elderly, infirm, frail, dependent or confused or have a poor prognosis or a combination thereof,

(b) a substantial proportion of patients are essentially helpless by virtue of a physical or mental impairment,

(c) for practical purposes, most patients are confined to nursing homes without choice, for want of a viable option.

14. *Defendants assert that:*

(a) There is a shortage of SNF and HRF beds in the State of New York. This shortage results in individuals who need SNF or HRF care actually not receiving either. Some of these individuals are in hospitals while others are in the community.

(b) This shortage is expected to persist into the near future.

(c) The projected shortage assumes a properly functioning utilization review (UR) process. If UR transfers are stopped, the shortage of beds will increase.

II. *Description of Defendants' System of Utilization Review*

15. Defendants have established a system of Utilization Review (UR) in nursing homes in New York State, pursuant to federal law and regulations, under which all patients in SNF's and HRF's are required to be periodically reviewed to determine if they remain eligible for the level of care they are receiving.

16. Defendants' policy is that UR applies only to Medicaid patients.

17. The Department of Health promulgated a long term care placement form, known as Form DMS-1 (Plaintiff's Exhibit 1).

18. Effective March 1, 1977, the Department promulgated a numerical scoring system for the DMS-1 form under which numerical points are assigned to certain items on the DMS-1 form (Plaintiffs' Exhibit 2) to determine the patients' "predictor score". The "predictor score" cut-off for SNF is 180 points and above; the cut-off for HRF is 60 points and above.

19. Questions 3D and 3E on the DMS-1 form ask whether the patient needs skilled nursing care; they document the need for skilled care.

20. The DMS-1 and numerical system are supposed to be used by the UR committee in each nursing home in assessing each Medicaid patient's need for continued stay.

21. For patients admitted to the facility prior to March 1, 1977, the DMS-1 form is supposed to be completed but the numerical standards and score are not supposed to be applied. The reason for this is defendants' fear that application of the numerical standards might bias the decision of the UR committee.

22. SNF patients are subject to UR following admission, at least once every 30 days for the first 90 days after admission, and at least once every 90 days thereafter.

23. HRF patients are subject to UR at least once every 6 months.

24. For purposes of UR, the DMS-1 is filled out by a registered nurse. This "nurse-assessor" is usually an employee of the facility.

25. The nurse who fills out the DMS-1 form ordinarily does not examine the patient.

26. *Defendants assert* that the nurse who fills out the DMS-1 is often a nurse with direct or supervisory responsibility for the patient. Accordingly, the nurse has first-hand knowledge of the patient's condition and is not dependent on the patient's records.

27. In some nursing homes, a special nurse, who is not involved in patient care, and who does not have personal knowledge of the patients, is hired to complete the DMS-1 forms.

28. *Defendants assert* that the special nurse may rely on other individuals with personal knowledge of the patient.

29. Defendants' policy regarding review of cases by the UR committee, following completion of the DMS-1 form, is as follows:

(a) cases are initially screened by a "screener", (who may be the same person as the "nurse assessor"), a non-physician member of the UR committee who need not be a nurse.

(b) if the "screener" determines that the case meets the criteria for continued stay, the patient is approved and the case is not referred to the physician member(s) of the committee; an SNF patient who receives more than 180 points or an HRF patient who receives more than 60 points is automatically approved.

(c) cases in which it appears to the "screener" that the patient no longer requires the current level of care and/or does not meet the DMS-1 criteria and numerical standards (i.e, less than 180 points for an SNF patient, less than 60 points for an HRF patient) are supposed to be referred to the physician member(s) of the committee.

(d) ordinarily the review is conducted by one physician member of the UR committee.

(e) the physician does not personally examine the patient but is supposed to review the DMS-1 form, any accompanying documents and any other information he thinks necessary. He may consult with other non-voting members of the UR committee, such as the social worker.

(f) the UR physician then decides whether continued stay is necessary. In doing so, he may consider psycho-social factors. After making his initial finding he must indicate and certify the patients' level of care needs on the back of the DMS-1 form.

(g) if the initial finding is that continued stay is not necessary, he is supposed to notify the patient's attending physician within 1 working day of this finding.

(h) the attending physician has 2 working days from the notification date to respond. If attending physician fails to respond, the decision of the UR physician is final. If the attending physician disagrees, the decision requires the concurrence and certification by a second UR physician.

30. The UR committee is supposed to be established by the facility and to consist of two or more physicians and other personnel selected and appointed by the facility. The physician members are reimbursed for their services by Medicaid.

31. Utilization review physicians are not supposed to be attending physicians of the patient being reviewed, but may be attending physicians for other patients in the same facility.

32. It is the defendants' policy that a staff physician of a facility cannot be a UR physician for that facility. However, under defendants' policy an attending physician who receives a substantial part of his income from attending to patients in a facility, may be the utilization review physician for persons who are not his patients at that facility.

33. Relevant psychosocial or other supplemental information is supposed to be considered by the UR committee

and may be added or attached to the DMS-1 form, although ordinarily such information is not added or attached to DMS-1 forms.

34. *Plaintiffs assert* that:

(a) ordinarily the utilization review physician does not consult with the non-voting members of the utilization review committee prior to making a utilization review determination.

(b) defendants do not know whether, or to what extent, utilization review committees actually take psycho-social factors into account in making their determinations.

(c) many UR committees use the numerical point system as the sole or predominant factor of placement and fail to consider relevant psycho-social factors.

35. *Defendants assert* that implicit in the URCs function to determine whether a particular individual can be transferred to a lower level of care, is the requirement to consider psycho-social factors which might impact on that determination.

36. The patients' "attending physicians" in a number of facilities are not staff physicians ordinarily on the premises, but are outside physicians who may be on the premises only infrequently.

37. Ordinarily, "attending physicians" do not attend UR committee meetings.

38. Ordinarily "attending physicians" find out about an initial adverse UR finding, if at all, in writing, by mail.

39. Defendants do not know the extent to which attending physicians receive information about initial UR findings or

final UR determinations or, if so, the extent to which they respond to this information.

40. *Plaintiffs assert* that patients' attending physicians are often not afforded a meaningful or adequate opportunity to respond to a preliminary UR finding.

41. Most adverse UR determinations, recommend relocation from one type of long term care institution (SNF, HRF, DCF) to another; few involve discharges to the community, to which patients ordinarily desire to return if they can.

42. Ordinarily, the Utilization Review Committee makes a recommendation regarding the level of care that the patient purportedly requires.

43. Ordinarily, the utilization review committee's recommendation specifies only the level of care and is not more specific regarding such matters as geographic placement location, particular facility characteristics, or specific facility or facilities.

44. Ordinarily, questions such as geographic placement location, particular facility characteristics, or specific facility or facilities are not decided by the committee but are decided afterwards in planning the discharge recommended by the committee.

45. *Plaintiffs assert* that within the particular level-of-care designation—SNF, HRF and DCF (adult home)—there is a substantial amount of variability between individual facilities in their ability to provide care and services for persons with varying degrees of need. A facility's level-of-care, as opposed to its individual characteristics, cannot be relied on as a basis for determining whether the facility is an appropriate placement in a particular case.

46. *Defendants assert* that UR committees can place limits or conditions on proposed transfers. For example, where appropriate, the transfer could be limited to within a multi-level facility. Limitations can be based on psychosocial factors.

47. There is no written documentation or training material for UR doctors, attending physicians, nurses, or UR screeners, describing or defining adult homes.

47. *Plaintiffs assert that:*

(a) SNF and HRF patients, whose DMS-1 forms reflect needs and disabilities which cannot be met in an adult home are nonetheless recommended by UR committees for transfer to adult homes.

(b) A large number of SNF and HRF patients, whose DMS-1 forms reflect needs and disabilities might be met in some adult homes but not others, are nonetheless recommended by UR committees for transfer to adult homes.

(c) The Division of Adult Residential Care of the Department of Social Services (DARC) does not specifically know which adult homes can or cannot meet the needs of such patients.

49. *Defendants assert that:*

DCF's may not accept or retain persons who require the following services or exhibit the following conditions:

(1) chronic, unmanaged incontinence, including use of catheters or colostomies that are not self managed;

(2) chronically bedfast, chairfast and unable to transfer;

(3) suffering from such a degree of mental illness and/or habituation or addiction to alcohol or other drugs such that the individual is causing or may cause

danger to himself or others or interferes with the care and comfort of other residents;

(4) incapable of self administration of required medication;

(5) in need of skilled observation of symptoms and reactions and the accurate recording of facts for purposes of reporting to the resident's physician;

(6) who is in need of a higher level of medical, mental health, or nursing care that can be rendered safely and effectively by approved community resources;

(7) in need of a medical, religious, cultural or dietary regimen that cannot or will not be met at the facility;

(8) suffering from a communicable or other disease of sufficient seriousness to constitute a potential danger to other residents and staff;

(9) in continual need of inhalation therapy treatments requiring use of oxygen or other explosive gases.

49a. *Defendants assert* that DARC has inspected all of the DCFs under its supervision. As of December 1978, 64% are in compliance, i.e., capable of providing service to persons in need of non-medical care and supervision. The remaining 36% have known violations and the process of correction and/or sanction is underway.

49b. The procedure and standards for UR in New York State are set forth in 10 NYCRR Part 400; 18 NYCRR § 505.9; 505.20, Department of Health Hospital Memoranda 77-9, 77-10, 77-13, 77-60, 77-74.

49c. In addition, defendants issued alleged "clarifying" instructions, Health Facilities Memo 78-39 and Social Services Directive 78-ADM-31, (Plaintiffs Exhibit 9) in the

summer of 1978, prompted by the pending lawsuit (*Yaretsky* v. *Blum*) and by certain task force meetings in New York and Albany.

49d. Health Facility Memorandum 78-39 contains the only explicit reference to consideration of "psychosocial factors" in making UR determinations, in defendants' regulations, memoranda and other promulgated materials.

49e. *Plaintiffs assert* that the manner in which the UR system is implemented was not significantly altered by the issuance of HFM 78-39 and 78 ADM-31.

III. *Notice of Adverse Determinations*

50. Defendants require that written notice, signed by the facility administrator, of the final UR determination that a patient can be transferred to a lower level of care, be sent to the patient, the patient's next of kin, attending physician and sponsor, within 3 days of the adverse UR determination.

51. The form of the notice that the facility is required to send following a UR determination which recommends transfer to a lower level of care, is Plaintiffs' Exhibit 20.

52. A decision, subsequent to an adverse UR determination, to reduce or terminate a patient/recipient's medical assistance or care, entitles the patient/recipient to notice a prior hearing and certain procedural rights (42 USC § 1396(a)(3), 45 CRF § 205.10):

> (a) a timely and adequate written notice must be sent to the recipient and his representative and that the notice must include:
>
> (1) [i] a statement of the proposed action;
>
> (ii) the specific regulations supporting such action;
>
> (iii) a full explanation of the individual's right to request a fair hearing, including the right of

unencumbered access to the recipient's case records and medical files as described in subparagraph (b) below;

(iv) the specific reasons for the intended action in the form of a written statement setting forth in specific detail the changed medical conditions which is signed by the utilization review physician who made the adverse determination;

(v) a copy of the adverse DMS-1.

(b) an adequate opportunity must be provided to the recipient and/or his representative to have reasonable access to examine before the fair hearing, the contents of the recipient's case file and facility medical records, as well as any other documents used by the utilization review committee in making its adverse determination and all documents and records to be used against the individual at the fair hearing.

53. The form of the notice which must be sent in such cases is Plaintiffs Exhibit 21.

54. *Plaintiffs assert* that:

(a) The required notice must be sent by the state or local agency and may not be delegated to the facility or UR committee.

(b) The notification procedures required by the preliminary injunction are not cumbersome to administer, inefficient or confusing to the patient.

(c) Abandoning direct local agency intervention and supervision in connection with notifying patients of their due process rights following an adverse UR determination, and relying instead for this task on facilities, would not benefit the patient or help streamline procedures.

(d) Past experience with relying on facilities or UR committees to provide such notification, indicates that such a system is not reliable as compared to the experience when the local agency sends this notice.

(e) Any slight administrative inconvenience is justified by the degree of additional protection afforded to patients when the local agency is required to send the notice.

(f) The right of access to records includes "medically contraindicated" information.

55. *Defendants assert* that:

(a) The required notice may be sent by the UR committee or the facility.

(b) Requiring the local social services agency to send the notice of adverse UR determinations creates a significant administrative burden and to the extent such requirement delays transfers, it effectively denies nursing home care to individuals who need it but presently are not receiving it. There are adequate alternative ways to make sure that patients receive the notices.

(c) The recipient is not permitted to have access to information which his doctor has stated, in writing, it would be medically contraindicated to disclose; although it does not limit the right of the recipient's representative to the information.

IV. *Policy Regarding Hearings For UR Recommended Transfers To Higher Level And Non-UR Related Transfers*

56. Since approximately July, 1978, it is defendant's policy that URC determinations which recommend a higher level of care are advisory opinions and not mandatory determinations. Medicaid payments will not be terminated if a patient refuses to comply with a URC recommendation that a higher level of care is needed.

57. It is currently defendants' policy that patients are not entitled to a hearing to review such determinations although a notice of determination is supposed to be sent.

58. *Plaintiffs assert* that:

(a) Defendants' practice prior to approximately November, 1978 was that patients who received an adverse UR determination recommending transfer to a higher level of care would receive a prior "fair hearing" to challenge the termination and that

(b) During the period that such hearings were granted, a significant number of such decisions were reversed on the merits.

59. *Defendants assert* that:

(a) It was defendants' practice prior to approximately July, 1978, that patients who received an adverse UR determination recommending transfer to a higher level of care could receive prior "fair hearings" to challenge the determination.

(b) During the period that such hearings were granted, there were approximately 10 hearings with approximately 5 of such decisions reversed on the merits.

(c) During the period July-September, 1978 defendants did inadvertently render a few decisions on the merits. Since September, the defendants have not rendered decisions on the merits where the URC recommended a higher level of care.

60. It is defendant's policy that patients recommended for transfer to another level of care by the facility, its agents or the patient's attending physician, do not have a right to prior notice and hearing to review such determination, although the patient may request that the

decision be reviewed by the URC and, upon such review, are entitled to the procedural rights described in paragraph 52 above. Defendants are presently reviewing this policy and may stop such reviews.

61. *Plaintiffs assert* that a substantial proportion of URC recommendations for transfer to a higher level of care and transfers recommended by the facility, its agent or the attending physician, are not proper under applicable federal and state regulatory prohibitions against arbitrary discharge.

V. *Representation And Counsel*

62. The statement in response to Question 15 of Health Facilities Memo 78-39 (Plaintiffs Exhibit 9) constitutes defendant's policy regarding the problem of representation of incompetent or confused patients.

63. *Plaintiffs assert* that:

(a) There are a substantial number of patients who are unable to cope with the utilization review procedures by themselves and who have no relatives or none who are interested or able to assist them in this area.

(b) There is no present system to identify patients who are unable to protect their interests upon receipt of an adverse UR determination, and are in need of legal advocacy assistance.

(c) There is no present system to provide legal advocacy assistance in all such cases.

(d) The due process rights of patients who do not have active family or other support system are rarely exercised.

64. *Defendants assert* that:

(a) Individuals are presumed competent.

(b) Facility social workers have the responsibility to identify patients who may need assistance in responding to URC recommendations that the patient be transferred to a lower level of care. The social worker can request fair hearings for such patients. The hearing officer is required to be especially protective of the rights of such patients.

VI. *Fair Hearing Procedures*

65. Approximately 50 fair hearings challenging adverse utilization review determinations are held in a normal month.

66. Those fair hearings are ordinarily held in the patient/recipient's nursing home.

67. The UR physician(s) who made the adverse determination is not required to, and ordinarily does not, attend the hearing.

68. The hearing officers who conduct utilization review hearings have received no special training specifically relating to: (a) utilization review; (b) conducting UR hearings; or (c) making recommendations in UR cases.

69. *Defendants assert* that while hearing officers have no special training sessions for UR hearings, they do receive formal training for their general function of recommending factual findings.

70. The hearing officers who conduct these hearings:

(a) have not been supplied with a copy of 42 CFR 400 *et seq.;*

(b) do not have specific knowledge of the DMS-1 scoring system;

(c) decide what weight, if any, should be given to DMS-1 questions 3d, 3e and 3f on a case-by-case basis;

(d) are not informed, unless they specifically request, whether their recommendations are affirmed or reversed or the reasons why.

71. Following the hearing, the hearing officer ordinarily makes a recommendation which, along with the record, is sent to the Albany office of the Department of Social Services.

72. Phillip Nostramo, senior attorney with the Fair Hearings Bureau of the Department of Social Services, reviews all long-term care fair hearings cases sent up by the hearing officers.

73. At the Albany office of the Department of Social Services, the hearing officer's recommendation and fair hearing file is reviewed, a decision is made, and the decision is adopted by the Commissioner of the Department of Social Services or her designee.

74. The person(s) who review the UR fair hearing cases does not listen to a tape of the hearing nor is a transcript made of the testimony prior to the decision.

75. Defendants' policy with regard to affirming or reversing UR determinations after fair hearing is as follows:

(a) a DMS-1 form plus a statement of specific reasons signed by the UR physician are sufficient to establish a *prima facie* case affirming the UR determination;

(b) a representative of the local agency, or the UR committee, or the facility or other person, is not required to appear at the hearing;

(c) hearsay alone may be sufficient to support the determination;

(d) assuming a *prima facie* case as described in subparagraph (a) is made, a DMS-1 form is not dis-

qualified from serving as the basis for a decision affirming the UR determination solely by virtue of the fact that:

(1) it is not signed by the nurse who completed the form and/or the UR "screener" and/or the UR physician; and/or

(2) it does not indicate their recommended placement; and/or

(3) a numerical score is contained on the form although the patient was a "grandfathered" patient admitted to the facility prior to March 1, 1977; and/or

(4) DMS-1 Questions 3D-F, 9A-C, 10 or 11 are answered in a manner which is facially inconsistent with the recommended decision;

(e) a UR recommendation may be affirmed notwithstanding lack of evidence in the record that:

(1) the written notifications were provided per Health Facility Memorandum 78-8 and 78 ADM-1 (per the preliminary injunction);

(2) the written notification contained the address and/or phone number of available legal services or other advocate;

(3) the patient and/or his representative were provided with access to the patients' files and records per HFM 78-8 and 78 ADM-1 (i.e., per the preliminary injunction);

(4) the patient's attending physician was notified of the initial adverse UR finding and/or received the notice and/or had an opportunity to comment;

(f) no formal "burden of proof" standard (e.g., substantial evidence, preponderance, clear and convinc-

ing) has been applied heretofore in rendering fair hearing recommendations or decisions; henceforth, defendants' policy is that the standard is "substantial evidence".

76. *Defendants assert* that:

(a) The Department first reviews the file to determine whether the proper documentation is in the file, then reviews the evidence to see whether the UR committee's case has been rebutted, and, as a practical matter, generally decides matters on a preponderance of evidence standard.

(b) While hearsay alone is sufficient to support a URC determination, the medical records constitute legally admissible and competent evidence.

(c) The record indicates that the final UR determinations was sent to the attending physician and that if the attending physician subsequently sends in comments objecting to the transfer, the matter will be remanded to the URC for reconsideration.

(d) The UR physician's decision to transfer in spite of an inconsistent answer to DMS-1 Questions 3D, E, F, 9A, B, C, 10 or 11, constitutes an adequate basis to support the transfer.

VII. *Transfer Trauma and Possible Harm To Patients*

77. *Plaintiffs assert* that:

(a) Under the present system of long term care facilities and reimbursement in New York, defendants' UR/DMS-1 system has a very significant adverse impact on Medicaid patients in SNF's and HRF's.

(b) UR determinations recommending a lower level-of-care, which are not voluntarily accepted by the patient, are likely to be followed by either:

(1) a subsequent physical or psychological occurrence requiring reversal by the UR of its adverse finding;

(2) hospitalization;

(3) death.

(c) "Transfer trauma" is a name ascribed to the recognized phenomenon that the transfer of geriatric patients to an unfamiliar surrounding is associated with increased rates or mortality and morbidity.

(d) The anticipation of relocation is also associated with effects as severe as those caused by relocation itself.

(e) It is not presently possible to predict, with any degree of certainty, the likelihood or degree of transfer trauma associated with a relocation.

(f) The general characteristics of nursing home patients —e.g. elderly, infirm, frail, confused—are also those associated with a high risk of transfer trauma and transfer of such patients involves a generally high level of risk.

(g) The intense kind of pre-transfer preparations and post transfer follow-up necessary to significantly reduce the risks of transfer trauma, is not presently available and would require, *inter alia,* holding beds vacant in receiving facilities for a period of time as well as trained personnel to make it work.

(h) Such preparation and follow-up should be *required* in any case where transfer is unavoidable but it still would not reduce the risk to the point where transfer could become a preferred alternative.

78. *Defendants assert* that:

(a) Transfer trauma is a name ascribed to the alleged phenomenon that the transfer of geriatric patients to unfamiliar surroundings causes some psychological trauma. Expressly excluded is the concept that transfer trauma is significant enough to have physiological implications for the person transferred. Nor does transfer trauma cause increased rates of mortality or morbidity for those transferred.

(b) To the extent transfer trauma exists:

1. It is virtually unrelated to the anticipation of transfer.
2. Transfer patients quickly recover in their new surroundings from any adverse reaction.
3. The better the patient's health the less effect the transfer has on him.
4. It is reduced and can be eliminated by preparing the patient for the transfer.
5. It can be determined on a case by case basis whether trauma will occur.

79. The likelihood and degree of trauma associated with relocation (transfer trauma) is in part a function of the extent to which the relocation was voluntary and the degree of environmental change entailed by the relocation.

VIII. *Adequacy of DMS-1 and Quality of DMS-1 Assessments*

80. *Plaintiffs assert* that:

(a) As implemented, the DMS-1/UR system does not provide uniform, consistent or adequate assessments of patient needs.

(b) The DMS-1 and scoring system is inadequate.

(e) The results of its implementation are inconsistent and inadequate.

(d) The DMS-1 numerical system can easily be manipulated to achieve a desired outcome.

(f) Utilization review and non-UR transfers are used by facilities to rid themselves of patients they do not wish to retain.

(g) DMS-1 numerical scores do not correlate with the nursing-hour needs of patients the DMS-1 purports to describe, although nursing-hour needs are the principal determinant of a patient's level-of-care needs.

(h) It is difficult to prepare an adequate assessment if the medical records are not accurate and complete, although there is great variability in the quality of medical record keeping between facilities and the overall quality at many facilities is inadequate.

(i) The DMS-1 does not reflect psychological dependency, other psycho-social factors, psychiatric or behavioral problems, although a psycho-social assessment is a necessary part of patient assessment.

(j) Adequate consideration of psycho-social needs in the UR process requires that a psycho-social assessment be built into whatever assessment instrument is used.

81. *Defendants assert* that:

(a) The DMS-1 provides an adequate basis for a doctor to determine what level of care a specific individual requires.

(b) The DMS-1 is being filled out properly at the facilities. This is true both where the patient is eventually reviewed by the URC and where such review is unnecessary. The defendants have conducted various periodic checks to substantiate this.

(c) The DMS-1 scoring sheet is a useful and accurate tool to determine which cases require further review by the URC to see if the patient can be transferred.

(d) Since the development of the DMS-1 and the development of the scoring sheet, nursing home beds have been better utilized. The DMS-1, the scoring sheet and the UR process are all *partly* responsible for this improvement.

(e) The URC serves as an effective check to make sure that existing nursing home beds are used by those patients who need them.

(f) Level-of-care needs of patients are determined by the patients' conditions and, primarily, by the nursing needs of their condition.

82. The implementation of the DMS-1 form and numerical criteria in 1977 was met with opposition from health care providers and from professional and other sources.

83. *Plaintiffs assert* that:

(a) The present DMS-1 scoring system has been strongly criticized since its inception by health care providers, professionals and consumer advocates.

(b) A principal objection to the present DMS-1 system, at the time of its implementation and thereafter, was its failure to incorporate psycho-social factors into the form.

(c) The Department of Health has been aware of the shortcomings in the DMS-1, the numerical standards, and the way it is implemented since its promulgation but has failed to correct these shortcomings.

IX. *Defendant's Monitoring of Costs and Benefits of System*

84. Defendants are obligated (pursuant to 42 USC §§ 1396e(a), 1396(g), 1396x(j)(12) and (k), and 42 CFR

456.206) to maintain an effective program of monitoring and control of the UR process.

85. *Plaintiffs assert* that defendants have not effectively monitored or controlled the functioning of the UR process.

86. Defendants are required pursuant to 42 USC 1396a (a)(19) and 45 CFR 206.10(a)(11) to provide such safeguards as may be necessary in the operation of the long term care system in New York, to assure that eligibility for care and services will be determined, and that care and services will be provided in a manner consistent with simplicity of administration and the best interests of the recipients.

87. *Plaintiffs assert* that:

(a) Defendants' system of long term care in general, and the utilization review system in particular, do not operate in a manner which is consistent with either simplicity of administration or the best interests of patients.

(b) Defendants have failed to provide the safeguards necessary to assure that eligibility is determined and care provided in a manner consistent with simplicity of administration and the best interest of patients.

88. *Defendants assert* that:

(a) The UR system is required by federal law. UR also guarantees proper utilization of scarce medical resources.

(b) As there is a present shortage of SNF and HRF beds, the transfer of a patient to a lower level of care ordinarily results in another patient filling the vacated bed. Accordingly, there are no short term financial savings in nursing home costs.

(c) The UR process reduces inappropriate placements and continued stays in nursing homes. Accordingly, it may reduce the number of nursing home beds that would other-

wise have been thought necessary in the future. This may result in some long term savings.

(d) To the extent the UR process results in patients being moved from hospitals to newly available nursing home beds, there are some cost savings.

(e) Defendants allege the present UR system has a positive utility which justifies its costs.

(f) It is medically undesirable for a patient to receive more care than he needs. For example, a patient requiring only HRF care will be better off in an HRF than in a SNF or in a hospital.

89. *Plaintiffs' assert* that whatever the theoretical benefits to defendants of the UR system, these benefits are not realized because the fact that:

> (a) the UR system itself entails a very substantial administrative cost (exclusive of the human cost extracted from the patients) and
>
> (b) the UR system does not result [in] a sufficient overall number of transfers or free a sufficient number of beds to fulfill defendants' objectives or to justify the cost.

90. *Plaintiffs assert* that in actual practice defendants UR system

> (a) has not worked to reduce Medicaid expenditures through the differential in reimbursement rates between higher and lower levels of care;
>
> (b) has not produced cost savings or other economic benefit;
>
> (c) has not fulfilled any economic or other legitimate governmental objective.

91. *Plaintiffs assert* that the time spent by nursing home professional staff in completing DMS-1 forms and in doing other related UR tasks has a significant impact in reducing the amount of such time spent on caring for patients.

92. *Defendants assert* that the staff needs, if any, which are created by the time spent on the UR process are met by the facilities adding additional staff.

93. Defendants have not conducted any specific study of DMS-1's in adverse UR determinations to determine whether they were properly filled out and properly matched to the patient.

94. Defendants do not know:

(a) how many patients receive adverse UR determinations;

(b) the number of [sic] percentage of such patients who disagree with the determinations;

(c) the percentage of such cases which are appealed by request for hearing;

(d) the number or percentage of patients who are transferred as a result of adverse UR determinations;

(e) what happens to patients who are transferred;

(f) what happens to patients who are not transferred;

(g) the economic costs of the present UR/DMS-1 system on patients;

(h) what is the impact of the present UR/DMS-1 system on patients.

94a. Defendants have not conducted any study or inquiry to determine the answers to (a)-(h) above.

95. Defendants rely on their fair hearing process to indicate whether its policies regarding utilization review are being followed.

96. *Defendants assert* that they also rely on Professional Medical Review (PMR) and Independent Professional Review (IPR) for this purpose.

X. *Possible Modifications of the DMS-1*

97. The Department of Health established a task force shortly after the DMS-1 numerical system was introduced, for the purpose of revising the DMS-1 and developing an alternative form, which would include a psycho-social assessment.

98. The chairman of that task force was David Glaser, administrator of the Margaret Tietz Center for Nursing Care and president of the New York Association of Homes for the Aging.

99. The task force included staff from the Department of Health, health care providers, health care professional, consumer representatives and others.

100. The task force developed a series of forms known as "PPAS" (Patient Placement and Assessment System) [Plaintiffs' Exhibit 11].

101. The PPAS incorporated DMS-1 form elements and added to them.

102. A field test of the PPAS was conducted by the Department of Health in the spring of 1978.

103. The field test was aborted because the particular forms proved unworkable.

104. The results of the field test were compiled by the Department of Health and issued by the Department in October, 1978. [Plaintiffs Exhibit 19].

105. *Plaintiffs assert* that:

(a) The "PPAS Task Force" was established in response to the outcry of criticism that accompanied the DMS-1 numerical system.

(b) The PPAS Task Force and the results of the field test reaffirmed: (1) the deficiencies in the present DMS-1 system and (2) the need to incorporate a psycho-social assessment into the form.

XI. *Possible Modifications of the Present Nursing Home Classification And Reimbursement System*

106. *Plaintiffs assert* that:

(a) Preferable alternatives to the present system of UR and long term care include:

(1) reclassification of beds within existing single level facilities to enable the large majority of level-of-care changes to be made without requiring relocation out of the facility;

(2) having a single all-inclusive level-of-care, and a single average reimbursement rate, covering both SNF and HRF;

(3) having beds whose classification shifts depending on the patient occupying it, thus enabling many level-of-care changes to be accomplished without transfer at all.

(b) To the extent accomplishment of the above requires waivers of federal requirements, the Department of HEW has granted such waivers.

107. Facilities which have level-of-care classifications enabling them to provide for several levels of care within the same facility are preferable to single level facilities.

108. Multi-level facilities make it easier to meet the long term care needs of smaller communities.

109. Transfer trauma (to the extent it exists) is less likely to occur and will be less significant when the transfer can

take place within a facility than if it requires relocation to another facility.

110. *Plaintiffs assert* that

(a) A UR recommendation of transfer which can be accomplished within a facility, is more likely to be voluntarily accepted by the patient and more likely to be actually carried out than one which would require out-of-facility relocation.

(b) From a fiscal and economic point of view, multiple levels-of-care are substantially more efficient and a better use of resources than single level facilities.

(c) From a medical perspective, nursing homes which offer a single level-of-care are:

(1) medically inferior to facilities which can provide for several levels of need within the same facility (i.e., multi-level) and

(2) are medically unacceptable.

111. SNF's and HRF's have different physical requirements. Most single level SNF's could meet or be easily adapted to meet HRF physical requirements (approximately 291 facilities).

112. *Plaintiffs assert* that most single level HRF's could also meet or be easily adapted to meet SNF physical requirements (approximately 30 facilities).

113. *Defendants assert* that the different physical requirements could render it virtually impossible for an HRF to meet SNF requirements. For example, SNFs must have bathrooms in each room. HRFs do not have such a requirement.

114. Medicaid reimbursement rates are cost-related. While the HRF reimbursement rate is ordinarily lower than the SNF reimbursement rate, HRF costs are also

ordinarily correspondingly lower than SNF costs. Thus SNF beds should not be more profitable to the operator of a nursing home.

115. *Plaintiffs assert* that

(a) Reimbursement mechanisms are available which would allow conversion of single level facilities to multi-level facilities.

(b) At present, the New York State Medicaid reimbursement formula builds in disincentives which discourage single level SNF's from seeking re-classification to multi-level facilities.

116. *Defendants assert* that there are no disincentives for single level facilities to convert to multi-level facilities.

117. At the time the present DMS-1 numerical system was implemented, defendants' "Task Force on Patient Assessment and Placement" (Task Force IV) (Plaintiffs' Exhibit 12), envisioned the re-classification of beds within the facilities to other levels of care with a result that single level facilities would be modified to multi-level.

118. At the time the present DMS-1 numerical system was implemented, it was the publicly stated position of the Deputy Commissioner of Health responsible for utilization review and development of that system, that:

a) By and large the policy has been that it's difficult, often inhuman and very often dangerous to take established patients from a long term care facility and require that they move to another facility.

b) Our intent is not to move anybody. Our intent is that there are patients who do not meet definitions of SNF. The way to handle that is to change the bed not the patient.

c) All facilities should be multi-level and should include the SNF, HRF and DCF categories. (Plaintiffs' Exhibit 13)

119. The reclassification of levels-of-care within facilities thus envisioned has, by and large, not been done.

120. The phased-in reclassification of most current single-level facilities to multi-level facilities is administratively feasible.

121. *Plaintiffs assert* that the Commissioner of Health can re-classify the level of nursing home beds to other levels of care.

122. *Defendants assert* that whether the Commissioner of Health has the legislative authority to re-classify the level of nursing home beds is an undetermined question of state law.

XII. *Plaintiffs' Summaries of DMS-1 Forms Analyzed*

124. Plaintiffs receive approximately 497 "notices of adverse UR determinations" with attached DMS-1's and statement of reasons, plus 29 adverse UR determinations from Westchester Co. facilities. These represent virtually every adverse UR determination from the time the *Yaretsky* preliminary injunction was implemented, on or about 2/1/78 up to 5/15/78.

125. Defendants provided the plaintiffs with approximately 500 DMS-1 forms for the month of September, 1978, which were randomly selected by the defendants.

126. Therefore, plaintiffs' DMS-1 analysis reviewed more than 1,500 forms (497+26+552+500).

127. The data in the sample of DMS-1 forms from September, 1978 is not significantly different from the data in the sample from January-March, 1978.

128. Plaintiffs' Exhibit 31 is a series of 19 tables which summarize data collected from those DMS-1 forms; the tables constituting plaintiffs' Exhibit 31 are accurate representations of what they purport to summarize and may be admitted into evidence.

129. *Plaintiffs assert* that the summaries are accurate representations of all DMS-1 forms, not just those summarized.

130. *Defendants do* not admit plaintiffs' assertion.

131. The following statements are true characterizations of the tables in plaintiffs Exhibit 31:

Table

1 The percentage of SNF and HRF patients is the same for adverse and non-adverse samples for all periods and is approximately equal to the overall statewide percentage: 70% SNF, 30% HRF.

2 Of the adverse UR decisions:

62.9% recommend SNF to HRF transfer;
23.9% recommend HRF to SNF transfer;
5.6 recommend SNF to "other-lower" transfer;
and 7.6% recommend HRF to "other-lower" transfer.

3 (a) Of the adverse UR DMS-1's, 28.6% are missing the UR "screener" signature.

(b) This is similar to the percentage missing the screener signature in both the Jan.-March (24.3%) and September (21.3%) non-adverse groups.

(c) 12.3% of the adverse DMS-1's are missing signatures of either the RN who completed

the form or the UR doctor; 9.2% are missing the UR doctor's signature, 11.1% are missing either the doctor's signature or his placement recommendation.

(d) In 3.5% of the adverse cases, the transfer decision reflected in the notice is different than that recommended by the UR doctor.

(e) A majority of non-adverse UR decisions for both the January-March (55.1%) and September (56.6%) periods were referred to and processed by the UR doctor.

4 (a) Of the adverse cases, 35% of the patients were identified on the DMS-1 as having been admitted prior to 3/1/77; of those 89.7% of the forms contained a numerical score.

(b) Of the non-adverse cases, 56.6% of the Jan.-March sample and 34.5% of the September samples were identified as having been admitted prior to 3/1/77; of those 61% and 56.1%, respectively, contained a numerical score.

5-6 (a) 19% of the notices of adverse UR sent out statewide did not list the address or phone of legal services; in New York City this percentage was 3%; upstate the percentage was 33.2%.

(b) 8% of the notices had no statement of reasons attached; of those that did, 27.3% did not state specific reasons for the adverse decision.

7 9 adverse DMS-1's indicated that the attending physician disagreed with the decision; in none of

those cases did the DMS-1 contain the signature of a second UR physician.

8 Attending physicans who are on staff (list same address as nursing home) are less likely to dissent from the UR determination (1 of 9 dissents) or 11.1%) in proportion to their numbers (28.7% of all adverse cases) than are attending physicians from outside the facility (representing 88.9% of dissents and 70.6% of all adverse cases).

9 (a) Of the patients recommended for transfer to HRF, the DMS-1 indicates that 17.8% require some item of nursing care and therapy listed in question 3A, and 15% suffer from incontinence.

(b) Of the patients recommended for transfer to adult home or other lower level, the DMS-1 indicates that 13.8% require some item of nursing care and therapy listed in question 3A, and 9.8% suffer from incontinence.

10 (a) Of the patients recommended for transfer to HRF, the DMS-1 indicates that 75.9% are likely to suffer complications and/or show instability requiring skilled nursing care or supervision; 61.7% indicate both.

(b) Of the patients recommended for transfer to adult home or other lower level, the DMS-1 indicates that 46% are likely to suffer complications and/or show instability requiring skilled nursing care or supervision; 36.4% indicate both.

(c) Of the patients recommended for transfer to SNF, the DMS-1 indicates that 16.4% are *neither* likely to suffer complications *or* show

instability requiring skilled nursing care or supervision.

11 (a) Of the patients recommended for transfer to HRF, the DMS-1 indicates that 72.3% require 7 days per week of skilled nursing care.

(b) Of the patients recommended for transfer to adult home or other lower level, the DMS-1 indicates that 54.9% require one or more days per week of skilled nursing care and 43.1% require seven days per week.

(c) Of the patients recommended for transfer to SNF, the DMS-1 indicates that 17.5% require no days of skilled nursing care, 30% require 4 or fewer days per week and 68% require 7 days per week.

12 (a) Of the patients recommended for transfer to adult home or other lower level, the DMS-1 indicates that 70.8% require some help in one or more functions areas and 10.8% require total help (or "cannot") in one or more areas.

(b) Of patients recommended for transfer to HRF, the DMS-1 indicates that 13.1% require total help (or "cannot") in one or more areas.

13 (a) Of the patients recommended for transfer to adult home or other lower level, the DMS-1 indicates that 63.6% are "sometimes" impaired in one or more mental status categories and 6.1% are always impaired (or never alert).

(b) Of the patients recommended for transfer to HRF, the DMS-1 indicates that 8.9% are always impaired (or never alert) in one or more mental status categories.

14 (a) In 32.5% of the adverse UR cases recommending transfer, the RN who filled out the DMS-1 indicated that the patient should not be considered for another level of care.

(b) In an additional 6.6% of the cases, the RN who filled out the form did not answer the question.

15 (a) Of the patients recommended for transfer to adult home or other lower level, the DMS-1 indicates that 37.5% are considered medically qualified for SNF care under Medicare standards; 49.7% are listed as questionable; 20.8% are listed as not covered.

(b) Of the patients recommended for transfer to HRF, the DMS-1 indicates that 59.8% are considered medically qualified for SNF care under Medicare standards; 27.4% are listed as questionable; an 12.7% are listed as not covered.

(c) Of the patients recommended for transfer to SNF, the DMS-1 indicates that 29% are *not* considered medically qualified for SNF care; 4.3% are listed as questionable.

16 7% of the adverse cases were free from facial defect or inconsistency.

17 Men patients are somewhat more likely to be recommended for transfer than are women (30.7% in adverse group vs. 25.4% in Jan-March and 26.9% in September non adverse groups).

18 Of the patients recommended for transfer, the mean age is 77.9 years, the mode is 81-85, 80.8% are more than 70 years old, and 93% are more than 60 years old.

19 162 nursing homes account for 100% of the adverse UR recommendations for the period of approximately 2/1/78 to 5/15/78; 22 homes account for 43% of the cases; 9 homes account for 24% of the cases.

Plaintiffs' Summaries for Fair Hearings Files Analyzed

132. Plaintiffs received from the defendants approximately 150 fair hearing decisions with supporting documents. Of these, 48 are fair hearings rendered in November and December, 1977 (period one); 53 are decisions rendered in May and June of 1978 (period two); and 46 are decisions rendered in September, 1978 (period three).

133. The 147 fair hearing decisions received by plaintiffs represent all fair hearing decisions rendered by the Department of Social Services for the months of November and December, 1977, and May, June and September of 1978.

134. Plaintiffs' Exhibit 30 is a series of 17 charts which summarize data collected from these fair hearing files. Charts No. 1, 6, 7 and 17 are based on a review of all 147 files. The remaining charts are based on a review of 106 files: a random sample of 30 and each from periods one and two, plus all 46 files from period three.

135. The charts constituting plaintiffs' Exhibit 30 are accurate representations of what they purport to summarize and may be admitted into evidence.

136. *Plaintiffs assert* that the summaries are accurate representations of all UR fair hearing files.

137. *Defendants* do not admit plaintiffs' assertion.

138. The following statements are true characterizations of the charts constituting plaintiffs' Exhibit 30:

Pretrial Order

(Statements Derived From Chart Nos. 1, 6, 7, and 17)

(a) 4 nursing homes account for 20% of all fair hearings; 11 homes account for 40 % (58/147) of all hearings; and 31 homes account for 70% (102/147) of all hearings.

(b) 75% (110/147) of all fair hearings were requested by patients in single level facilities.

(c) Single level SNF's account for 94% of all hearings requested by SNF patients. (86/91)

(d) 62% of all the hearings held involved transfers out of an SNF facility. (91/147)

(e) 12% of the hearings involved upward transfers from an HRF to an SNF. (17/147)

(f) In 60% of the hearings involving the issue of an upward transfer from HRF to SNF, the patient/recipient prevailed at the fair hearing.

(Statement Derived From the Remaining Charts)

(a) 16% of the hearings were pro se.

(b) Unrepresented clients lost 60% of their hearings, compared with a 43% average loss by represented patients.

(c) of 106 decisions, the recommendation of the hearing officer (hereinafter H.O.) was adopted by Albany in 56 cases, reversed in 15 cases, in nine there was "no issue"; and in 26 cases the hearing officer did not make a recommendation.

(d) Albany reversed the H.O's recommendation in 12 out of 39 cases (or 31%) where the H.O. made a recommendation in favor of the appellant; Albany reversed the H.O.'s recommendation in 3 out of 32 cases (or 9% where the H.O. made an adverse recommendation. In the more recent cases of September 1978 (period 3), Albany reversed the H.O.'s recommendation in 9 out of 19 cases

(or 47%) where the H.O. made a recommendation in favor of the appellant.

(e) Where Albany decides differently than the hearing officer, Albany's decision is for transferring the patient in 80% of the cases; for September, 1978 the percentage is 90%.

(f) In 24% of the hearings, the DMS-1's relied upon did not have the signature of the utilization review committee representative, and in 60% of these cases the fair hearing decision upheld the transfer.

(g) In 8% of the hearings, the DMS-1 relied upon was not signed by the utilization review committee physician. In 3% of these cases the fair hearing decision upheld the transfer.

(h) In 30% of the cases, the patient was admitted to the facility prior to March, 1977, yet the DMS-1 relied upon as scored. In 81% of these cases the fair hearing decision upheld the transfer.

(i) In 38% of the cases, on the DMS-1 Form question #D (Is the patient's condition unstable so then an RN must detect/evaluate need for modifications treatment/care on a daily basis?) was either left blank or answered "yes." In 38% of these cases the fair hearing decision upheld the transfer.

(j) In 42% of the cases, question 3E on the DMS-1 (Is there a high probability that complications would arise in caring for the patient without skilled nursing supervision of the treatment program on a daily basis?) was either not filled out or was answered "yes." In 49% of these cases the fair hearing decision upheld the transfer.

(k) In 41% of the cases, question 3F on the DMS-1 (Circle the *minimum* number of days/weeks of complex

nursing supervision) was either not filled out or was filled out indicating seven days per week required. In 49% of these cases the fair hearing decision upheld the transfer.

(l) In 35% of the cases, question 9A (Should the patient be considered for another level of care?) was not filled out or was answered "no." In 54% (20/37) of these cases the fair hearing decision upheld the transfer.

(m) For hearing decisions rendered in periods 2 and 3, 49% of the "statements of exact reasons" were not signed by the utilization review physician. In 58% of these cases the fair hearing decision upheld the transfer.

(n) For hearing decisions rendered in periods 2 and 3, 32% had "statements of exact reason" that did not specify change or improved conditions of the patient. In 58% of these cases the fair hearing decision upheld the transfer.

(o) For the "facial" errors set forth in sub-paragraphs f through n, there appear to be no overall pattern of improvement from period 1 through period 3.

(p) The rate of "facial errors on DMS-1's for which fair hearings were requested is approximately equal to the facial error rate of all adverse DMS-1's. (Fair hearing and DMS-1 summary).

(q) For period 1, in 9 of the decisions which were affirmed, the decision was based on documents submitted by the agency without the agency representative present, although the only other evidence was appellant witnesses opposing transfer.

(r) For period 3, this was true in 4 cases which were affirmed.

(s) For period 3, of the 20 hearing decisions not affirmed, at least 8 were not affirmed for technical defects in procedures; at least 6 were based on a change in the patient's

physical status or a report by a physician made after the initial DMS-1.

(t) For period 2, at least 8 of the 15 decisions not affirmed were on grounds of procedural irregularities.

XIV. *Status of Admissions Made At Depositions*

139. The statements in the depositions of the following persons are the statements of defendants (except as otherwise stated in the depositions) and such statements may be admitted into evidence:

Elizabeth Dinehart
Roger Herdman
Anthony Maddaloni
Phillip Nostramo
Richard Ruid
Henry Stevenson

* * *

March 5, 1979
N.Y., N.Y.

So ordered
/s/ Constance Baker Motley
United States District Judge

Notice of Motion for Summary Judgment

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

SIRS:

PLEASE TAKE NOTICE, that upon the annexed Local Rule 9(g) statement of material facts as to which plaintiffs contend there is no genuine issue to be tried, the letter of Sherry J. Leiwant, Assistant Regional Attorney for HEW, dated August 10, 1979, plaintiffs' memorandum in support of the instant motion, the depositions and plaintiffs' exhibits in this case, and upon all prior proceedings had and papers filed herein, including the stipulation of consent to entry of partial final judgment, dated May 29, 1979, the Joint Pre-Trial Order, signed March 5, 1979, and the plaintiffs' pre-trial memorandum, dated February 22, 1979, the undersigned will move this Court, before the Honorable Constance Baker Motley, in Courtroom 619 of the United States Courthouse, Foley Square, New York, New York, on September 21, 1979, at 10:00 a.m., or as soon thereafter as counsel can be heard,

1. for an order EITHER

(A)(1) directing that the stipulation of consent to entry of partial final judgment be entered as a partial final judgment, pursuant to paragraph XIII of said stipulation, on the ground that defendants' compliance with the judgment or any portion thereof will not cause federal financial participation in the New York State Medicaid Program to be terminated or reduced; and

(A)(2) pursuant to Rule 56 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2201, granting summary

judgment in favor of the plaintiffs and the plaintiff class, on the ground that there is no genuine issue as to any fact material to this case and that plaintiffs and plaintiff class members are entitled to a judgment as a matter of law, declaring (a) that they each have a constitutional right under the Due Process Clause of the Fourteenth Amendment to adequate notice and the opportunity for an evidentiary hearing prior to a transfer initiated by a nursing facility without utilization review and prior to transfer to a higher level of nursing care, and (b) that the Due Process Clause of the Fourteenth Amendment and the laws of the State of New York prohibit the State Commissioner of Social Services and his agent from rejecting and reversing a hearing officer recommendation after fair hearing favorable to a plaintiff or plaintiff class member without first preparing, reviewing, and adequately considering together with all exhibits, a verbatim transcript of the hearing; and

(A)(3) pursuant to Rule 65 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, granting a permanent injunction enjoining the defendants, and their officers, agents, servants, employees, attorneys, and successors in office, and all persons in active concert or participation with them who receive actual notice of this judgment by personal service or otherwise, (a) to enforce and comply with each and every provision of the partial final judgment, *supra,* (b) to provide every affected plaintiff and plaintiff class member with adequate notice and the opportunity for an evidentiary hearing prior to a transfer to a higher level of nursing care and prior to a transfer initiated by a nursing facility without utilization review, and (c) to prepare, review, and adequately consider, together with all exhibits, a verbatim transcript of the fair hearing prior to rejecting and reversing a hearing officer recommendation favorable to a plaintiff or plaintiff class member;

OR, IN THE ALTERNATIVE,

Notice of Motion

(B)(1) pursuant to Rule 56 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2201, granting summary judgment in favor of the plaintiffs and the plaintiff class, on the grounds that there is no genuine issue as to any fact material to this case and that the plaintiffs and plaintiff class members are entitled to a judgment as a matter of law, declaring that, under the United States Constitution, the Social Security Act and implementing federal regulations, and the laws of the State of New York, they each have all the rights set forth at pages 5-11 of the Joint Pre-Trial Order, signed March 5, 1979, in this case; and

(B)(2) pursuant to Rule 65 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, granting a permanent injunction enjoining the defendants, and their officers, agents, servants, employees, attorneys, and successors in office, and all persons in active concert or participation with them who receive actual notice of this judgment by personal service or otherwise, to enforce and comply with each and every provision set forth at pages 5-11 of the approved Joint Pre-Trial Order in this case; AND

2. for an order reserving for later determination by this Court, upon appropriate motion to be made at a time set by the Court, the issue of plaintiffs' entitlement to an award of reasonable attorneys' fees, expenses, costs, and disbursements in this case; AND

3. for an order granting such other and further relief as to this Court may seem just and proper.

Defendants are requested to serve their answering papers, if any, to this motion upon plaintiffs' counsel no later than 5:00 p.m., September 17, 1979.

Dated: New York, New York
September 11, 1979

Yours, etc.,

[Attorneys' subscriptions and addresses omitted in printing.]
Attorneys for Plaintiffs

Plaintiffs' Rule 9(g) Statement

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

Plaintiffs hereby incorporate into and as constituting this statement of material facts as to which there is no genuine issue to be tried the statements contained at pages 25-68 of the Joint Pre-Trial Order, signed March 5, 1979, except for the following numbered statements: Nos. 9, 14, 26, 28, 35, 46, 49, 49a, 55, 59, 64, 69, 76, 78, 81, 88, 92, 96, 113, 116, 122, 130, 137.

Dated: New York, New York
September 11, 1979

Respectfully submitted,

[Attorneys' subscription and addresses omitted in printing.]
Attorneys for Plaintiffs

Affidavit of Philip M. Gassel

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

STATE OF NEW YORK
COUNTY OF NEW YORK } ss.:

PHILIP M. GASSEL, being duly sworn, deposes and says:

1. I am one of the attorneys for the plaintiffs and make this affidavit in further support of plaintiffs' motion that the Court enter the parties' "Stipulation of Consent to Entry of Partial Final Judgment" as the judgment of the Court.

2. The grounds for said motion were that the precondition for entry of a judgment, set forth in the stipulation, has been satisfied. That precondition was the receipt of reasonable assurances from the Department of H.E.W. that the State will not lose federal Medicaid reimbursement (i.e. "federal financial participation," or "FFP") as a result of the judgment. The necessary assurances, plaintiffs contended, were contained in a letter, dated August 10, 1979, from HEW counsel to defendants' attorney (see plaintiff's memorandum in support of the motion, at pp. 4-6, and letter annexed thereto).

3. Following receipt of the August 10 letter, defendants' counsel expressed dissatisfaction with the assurances contained therein. Conversations ensued between counsel for plaintiffs, defendants and HEW, on September 4, 5 and 6, 1979 regarding modifications of the letter which would satisfy the state. After conferring with his clients, defendants' counsel negotiated with counsel for HEW regarding the addition of certain clarifying language to the letter. A

verbal agreement was reached in which counsel for defendants expressly represented to me, based on his conversations with his clients and with HEW, that receipt of a letter from HEW with the requested clarification, would be satisfactory and permit entry of the judgment. I was told by counsel for HEW that defendants' counsel made a similar representation to her.

4. Subsequent to the filing of this motion for entry of judgment based on the settlement stipulation, HEW Regional Administrator William Toby sent a letter to defendants' attorneys, dated September 13, 1979. (Copy attached hereto). Per the verbal agreement, the letter contains all of the elements of the earlier August 10 letter plus the agreed upon statements of clarification.

5. I have since been advised by defendants' counsel that his clients are still not satisfied. I am further advised that their dissatisfaction concerns a sentence in Mr. Toby's letter referring to possible loss of reimbursement for individual patients "in the event that an HEW audit found that an individual patient had stayed in a skilled nursing facility despite a utilization control determination that he did not need skilled nursing care." Although this sentence is taken verbatim from the earlier August 10 letter, no objection to it has heretofore been expressed by defendants. Indeed, at a meeting at the HEW offices regarding the settlement, on July 10, 1979, which I attended, George M. Warner, M.D., Assistant to the Deputy Director, Division of Health Facilities Standards and Control of the N. Y. State Health Department Office of Health Systems Management, stated the willingness of the Department of Health to, if necessary, absorb possible individual Medicaid "disallowances" of this type.*

---

* Plaintiffs' memorandum in support of this motion (p. 6) explains why, in any event, no such disallowance can occur under the terms of the settlement stipulation.

6. In light of defendants' verbal agreements and representations described above, the September 13 letter from HEW is sufficient, without more, to permit entry of judgment on the stipulated settlement previously signed by the parties.

s/ PHILIP M. GASSEL

Sworn to before me this
20th day of September, 1979.
[Jurat omitted in printing.]

Affidavit of Kenneth A. Thomas in Support of Motion to Join HEW as a Defendant and in Opposition to Motion for Summary Judgment

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

STATE OF NEW YORK }
COUNTY OF NEW YORK } ss.:

KENNETH A. THOMAS, being duly sworn, deposes and says:

1. I am an Assistant Attorney General in the office of ROBERT ABRAMS, Attorney General of the State of New York, attorney for defendants and I make this affidavit in opposition to plaintiffs' motion for an order directing that the stipulation of consent to entry of partial final judgment be entered as a partial final judgment pursuant to paragraph XIII of said stipulation on the ground that defendants' compliance with the judgment or any portion thereof will not cause federal financial participation in the New York Medicaid Program to be terminated or reduced and in support of defendants' motion to join the United States Department of Health, Education and Welfare as a party to this action pursuant to Rules 19 and 21 of the Federal Rules of Civil Procedure.

2. On May 29, 1979, plaintiffs and defendants, by their respective attorneys, executed a stipulation of consent to entry of partial final judgment ("the stipulation") which, if entered as a judgment, would settle many of the issues raised in this lawsuit including all those issues which would have required a trial. Among the issues covered by

the stipulation were the alleged inadequacies in utilization review procedures, as well as, the effect of transfer trauma on nursing home patients.

The stipulation, a copy of which was forwarded to the Court on May 29, 1979, requires, among other things, that the utilization review committee receive and consider a written and signed psycho-social evaluation indicating the patient's response to possible transfer, that a written discharge plan be prepared for the patient to be transferred and that no transfer may be approved where there exists certain defects in the underlying paperwork. (See Stipulation ¶ II, A-D.) The stipulation, also spells out certain procedural rights of patients faced with transfer including the right to timely and adequate notice of an adverse utilization review finding and the right to have unencumbered access to review and copy the contents of their file. (See Stipulation ¶ III.) The issue of transfer trauma was resolved in the stipulation by providing that a proposed transfer of a patient is medically contra-indicated unless the patient voluntarily consents to the transfer. (See Stipulation ¶ II, F.)

3. It is the position of the State defendants that the stipulation is in the best interests of both the State and nursing home patients since it affords greater protection to patients facing transfer while improving the utilization review procedures. (See affidavit of Robert F. Skerrett, Acting Deputy Commissioner of the New York State Department of Social Services, sworn to September 19, 1979, ¶ 3, hereinafter "the Skerrett affidavit").

4. As set forth in the Skerrett affidavit, the federal government provides approximately 50% of the funds for the Medicaid program in New York State. (See Skerrett affidavit, ¶ 6.) Federal funding of this program, which includes funds for patients in nursing homes, can be taken

away where the United States Department of Health, Education and Welfare ("HEW"), determines that the State is not administering the program in accord with federal regulations.

Since the stipulation requires changes in the State's administration of utilization review, the State defendants were concerned that implementation of the stipulation could jeopardize federal financial participation in the Medicaid program in New York State. Consequently, at defendants' request paragraph XIII of the stipulation provides, in part:

> "Defendants are not bound by and judicial approval of this judgment shall not be sought by the parties until the U.S. Department of Health, Education and Welfare (hereinafter "HEW") represents, or it is judicially determined, that defendants' compliance with this judgment or any portion thereof will not cause federal financial participation (hereinafter "FFP") in the New York State Medicaid Program to be terminated or reduced . . ."

5. In a letter dated May 29, 1979, plaintiffs and defendants forwarded to William Toby, Regional Administrator, Health Care Financing Administration, HEW, a copy of the stipulation and formally requested HEW to review the stipulation and advise them "whether FFP in the State's Medicaid program, under Title XIX of the Social Security Act, will be terminated or reduced if defendants comply with a federal court order incorporating the terms of the stipulation." A copy of the letter is annexed hereto as Exhibit A.

6. Subsequent to the May 29, 1979 letter to HEW, plaintiffs and defendants met with representatives of HEW and entered into further discussions which culminated in a September 13, 1979 letter from Mr. Toby to Attorney Gen-

eral Robert Abrams advising the State what possible effect implementation of the stipulation might have on receipt of FFP by the State for the Medicaid program. While HEW did not express any views as to the likelihood that implementation of the terms of the stipulation would be contrary to federal utilization review requirements, HEW did represent that any loss of FFP as a result of a finding that the State was out of compliance with federal utilization review requirements, Title XIX, or the New York State Plan would be prospective only. However, HEW stated that the State could lose FFP as a result of implementation of the stipulation in the event that a HEW audit found that an individual patient had stayed in a skilled nursing facility despite a utilization review determination that he did not need skilled nursing care. In that event, federal payments for that individual patient could be disallowed.

7. It is impossible to estimate the number of patients who might be effected by a HEW audit as described in the Sept. 13, 1979 letter. The number of such patients may be indicated by the number of fair hearings requested by patients who object to adverse utilization review determinations since such patients would be likely to exercise their right to withhold consent as to a proposed transfer. On the other hand, the number of such patients may be much higher since there may be many patients now being transferred who would refuse to give their consent to a transfer if that option were available but who do not pursue their right to an administrative appeal. (See Skerrett affidavit, ¶ 7.)

8. It is the position of the State defendants that the possible loss of FFP through a HEW audit is serious and could result in the withholding of a substantial amount of federal funds. Consequently, the State defendants do not believe that the representations contained in the May 29,

1979 letter assures them that FFP will not be reduced or terminated as a result of implementation of the terms of the stipulation as required in paragraph XIII of the stipulation.

9. While the proposed amendments to the regulations of the New York State Department of Health reflecting the terms of the stipulation were not forwarded to HEW until recently, HEW has had a copy of the stipulation since May 29, 1979. Since HEW has had a copy of the stipulation for almost four months and has had continuing discussions with the parties regarding the stipulation during that time, it is reasonable to believe that HEW has had an opportunity to form an opinion as to whether the terms of the stipulation comport with federal regulations.

10. Upon information and belief, HEW's reluctance to state its views as to whether the stipulation comports with federal requirements is based on HEW's objection to that portion of the stipulation which provides that an adverse utilization review finding is medically contra-indicated where the patient does not voluntarily consent to the proposed transfer. (See Stipulation, ¶ II, F.)

11. Defendants agreed to the inclusion of the provision regarding the necessity of patient consent to transfer for two reasons. First, there exists a widespread phenomena known as "transfer trauma" which is the anxiety experienced by an elderly patient when moved from or even faced with the threat of being moved from a nursing home which he has come to view as his home to another institution. Further, it appears that transfer trauma can cause a deterioration of the patient's health leading in some cases to his death. Secondly, it appears that there is at present no way to know which patients who object to being transferred out of a facility will suffer from transfer trauma and which will not.

Therefore, the State defendants concluded that, given the current state of medical understanding of transfer trauma, the only way to protect the patient's health is to require that he consent to any proposed out-of-facility transfer.

12. If HEW objects to the State's position that nursing home patients ought not to be transferred against their will, now is the time for HEW to present its case. It would certainly better serve the interests of the economical administration of justice if HEW were to be required as a party to the action to either accede to the terms of the stipulation or to present its case against it now and before this Court rather than being able to collaterally attack the stipulation several months or years hence by withholding federal funds from New York State.

13. Furthermore, it is clear that HEW has an interest in this action since the interpretation of federal regulations regarding utilization review are at issue and since federal funds pay for half of the Medicaid program.

14. In the instant motion, plaintiffs, also, seek an order granting summary judgment with respect to two issues of law among those not disposed of by settlement (see Stipulation ¶ VIII, A, 1-2) or, in the event the stipulation is not entered as a judgment, summary judgment as to relief requested by plaintiffs in the joint pre-trial order, as well related permanent injunctive relief. In the event that defendants' motion to join HEW as a party is granted and HEW chooses to defend the action rather than accede to the stipulation, it would seem appropriate for plaintiffs to request this relief in the context of a post-trial motion. Alternatively, should HEW accede to the stipulation or should the Court determine that the State defendants have reduced or terminated so as to

warrant entry of the stipulation as a judgment then there would be no trial and the parties could proceed expeditiously, to submit for the Court to consider the issues of law set forth in ¶ VIII, A, 1-2 of the stipulation.

Therefore, defendants respectfully request that plaintiffs' motion for summary judgment be held in abeyance pending the Court's decision with respect to plaintiffs' motion for entry of the stipulation as a judgment and defendants' motion to join HEW.

WHEREFORE, for the reasons set forth herein, in the accompanying affidavit of Robert F. Skerrett and memorandum of law, it is respectfully requested that plaintiffs' motion for an order directing that the stipulation of consent for entry of partial final judgment be entered as a partial final judgment, pursuant to paragraph XIII of said stipulation on the ground that defendants' compliance with the judgment or any portion thereof will not cause federal financial participation in the New York Medicaid Program to be terminated or reduced be denied and that defendants' motion to join HEW as a party to this action be granted.

s/ KENNETH A. THOMAS

Sworn to before me this
19th day of September, 1979
[Jurat omitted in printing.]

Affidavit of Kenneth A. Thomas in Opposition to Motion for Summary Judgment

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

STATE OF NEW YORK }
COUNTY OF NEW YORK } ss.:

KENNETH A. THOMAS, being duly sworn, deposes and says:

1. I am an Assistant Attorney General in the office of ROBERT ABRAMS, Attorney General of the State of New York, attorney for defendants and I submit this affidavit in opposition to plaintiffs' motion for summary judgment.

2. The joint pre-trial order contains several factual assertions which are disputed by the parties. Factual assertions made by plaintiffs which are disputed by defendants are identified by paragraphs numbered "34", "40", "47", "49e", "54", "58", "77", "80", "83", "85", "87", "89", "90", "91", "105", "106", "110", "112", "115", "121", "129", and "136". Factual assertions made by defendants which are disputed by plaintiffs are identified by paragraphs numbered "9", "14", "26", "28", "35", "46", "49", "49a", "55", "59", "64", "69", "76", "78", "81", "88", "92", "96", "113", "116", "122", "130" and "137".

3. As set forth in the pre-trial order, the disputed issues of fact involve, among other things, the extent to which the utilization review process is now taking into consideration

psycho-social factors in considering whether to recommend transfer of a patient to a lower level of care. Defendants assert that implicit in the UR committee's function is the requirement to consider psycho-social factors which might have an effect on a UR determination. (Pre-trial order, ¶ 35.) If it can be shown that UR committees are adequately taking psycho-social factors into consideration when making a decision on a proposed patient transfer then it can not be said that the UR procedures are per se inadequate. See Pre-trial order, Factual issues underlying plaintiffs' claims for relief No. 5.

4. Plaintiffs contend that the UR committee person who makes an adverse UR decision should be required to personally examine the affected patient. Pre-trial order, page 7. However, if as defendants assert, the nurse who fills out the DMS-1 is often a nurse with first-hand knowledge of the patient's condition, this would be unnecessary. Pre-trial order, page 29.

5. As shown in the Pre-trial order, there is a dispute as to the adequacy of the DMS-1 as an instrument to guide a doctor in determining the appropriate level of care for a patient. Defendants contend that the DMS-1 scoring sheet is a useful tool enabling the better utilization of nursing homes. Pre-trial order pages 50-51. Plaintiffs contend that the DMS-1/UR system does not provide uniform, consistent or adequate assessments of patient needs. Pre-trial order, page 48.

6. The factual disputes set forth above and many others contained in the Pre-trial order demonstrate that there are significant disputed factual issues which require that plaintiffs' motion for summary judgment be denied.

Second Thomas Affidavit

7. One of the issues of law to be submitted to the court for determination in connection with the motion for summary judgment is whether state action is present with respect to UR transfers to higher levels of care. Pre-trial order, page 23.

8. As set forth in the attached administrative letter of defendant New York State Department of Social Services, it is defendant's policy that UR recommendation to transfer a patient to a higher level of care are advisory only. The patient's level of Medicaid reimbursement will not be terminated should he refuse to move notwithstanding a UR recommendation that he be transferred to a higher level of care. See New York State Department of Social Services 78 ADM-31, June 28, 1978 at Addendum #1, Question 1. Consequently, there is no state action present with respect to UR recommendations that a patient be transferred to a higher level of care.

WHEREFORE, it is respectfully requested that plaintiffs' motion for summary judgment be denied.

s/ KENNETH A. THOMAS

Sworn to before me this
10th day of October, 1979
[Jurat omitted in printing.]

Defendants' Rule 9(g) Statement

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

Defendants hereby incorporate into this statement of material facts as to which there is no genuine issue to be tried the statements contained at pages 25-68 of the Joint Pre-Trial Order signed March 5, 1979, except for the following numbered statements: "34", "40", "45", "47", "49e", "54", "58", "77", "80", "83", "85", "87", "89", "90", "91", "105", "106", "110" "112", "115", "121", "129" and "136".

Dated: New York, New York
October 10, 1979

Yours, etc.,

[Attorney's subscription and address omitted in printing.]

Attorney for Defendant

October 17, 1979 Partial Final Judgment

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
Civil Action No. 76 CIV 3360 (CBM)

WILLIAM YARETSKY, *et al.*,

Plaintiffs,

and

MARY FOLEY, *et al.*,

Plaintiffs-Intervenors,

—against—

BARBARA BLUM, *et al.*,

Defendants.

The Court, in January 1978, having found subject matter jurisdiction over this action and having certified this action as a class action, and in January, 1978 having issued a preliminary injunction with respect to certain procedural rights of the plaintiff class to adequate notice and access to medical records prior to hearing review of adverse utilization review decisions concerning patient level of care and level of Medicaid benefits, and the Second Circuit Court of Appeals in January 1979 having affirmed that preliminary injunction insofar as appealed from by defendants (592 F.2d 65), and this Court in June 1978 having issued a declaratory judgment, without injunctive relief, that State Department of Health Hospital Memoranda establishing defendants' utilization review policies and procedures regarding assessment of patient place-

ment needs are invalid for noncompliance with rulemaking requirements of the New York State Administrative Procedure Act (456 F.Supp. 653); and

The parties, by their respective attorneys, having presented for judicial approval the within Stipulation of Consent to Entry of Partial Final Judgment with its Addendum Concerning Monitoring and the Court having satisfied itself as to the fairness, adequacy, and propriety of the proposed Partial Final Judgment and Addendum Concerning Monitoring;

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that the Stipulation of Consent to Entry of Partial Final Judgment, with Addendum Concerning Monitoring, annexed hereto is the judgment of this Court.

SO ORDERED. ENTER JUDGMENT.

/s/ CONSTANCE BAKER MOTLEY
U.S.D.J.

DATED: New York, New York
October 17, 1979.

Judgment Entered
10/19/79

s/ RAYMOND F. BURGHARDT
Clerk

Stipulation of Consent to Entry of Partial Final Judgment

IT IS STIPULATED AND AGREED by and between the parties herein, through their respective attorneys, as follows:

I. The parties hereto share a mutual concern for the health and best interests of persons receiving care or services in, or residing in, a facility providing skilled nursing and/or health related care or services in the state of New York (hereinafter "facility"), and further recognize that all the provisions of this judgment, including those concerning the discharge or relocation to a lower level of care (hereinafter "transfer") of such persons (hereinafter "patients") further the best interests of the patients. The parties recognize it is the defendants' position that the considerations and evaluations which resulted in this judgment do not necessarily apply in contexts not within the judgment.

II. No finding, determination or other decision (hereinafter "finding") by a Utilization Review committee or agent, or a person or body performing the function thereof as an agent of defendants (hereinafter "UR" or "UR committee") recommending transfer of a patient to a lower level of care (hereinafter "adverse UR finding"), can be approved or implemented:

A. Unless the UR committee has received and considered:

1. a written and signed psycho-social evaluation indicating the patient's response to possible transfer, and additional written information describing the patient's current physical, emotional and mental condition and treatment plan;

2. a written and signed statement from the patient's attending physician describing the patient's current phys-

ical response to transfer, the current clinical status and whether the transfer is medically safe for the patient and in his/her best interest;

3. a written and signed discharge plan delimiting the proposed placement in sufficient detail to meet the particular placement needs of the patient (e.g., ability of the facility to provide suitable care and services for assessed needs of the patient, geographic constraints, accessibility to family).

B. Unless any medical and nursing portions of the DMS-1 or other assessment instrument provided to and considered by the UR committee is approved and signed by a registered nurse who is directly responsible for the patient's care (this requirement may be implemented by administrative letter).

C. If any assessment instrument or other document forming a basis for the UR committee's finding has an internal inconsistency.

D. If any assessment instrument or other document forming a basis for the UR committee's finding is illegible, partially incomplete, or missing an authorized signature, unless such defect is cured.

E. Unless the appropriate UR procedures established by defendants and described below, were followed, to wit:

1. that, in the case of a patient initially admitted to the facility prior to March 1, 1977 (regardless of intermittant hospitalization or temporary absence), the assessment instrument was not scored and numerical criteria were not applied;

2. that the case was reviewed, in turn, by the UR committee (or a subgroup including at least one UR physician), the patient's attending physician, and, if the

attending physician disagreed with the UR physician, at least one other UR physician after consideration of the attending physician's views;

3. That each person described in subparagraph E.2 *supra*, finds that transfer of the patient to a lower level of care would be proper, as defined in paragraph F *infra*, except for the attending physician in a case where he/she is overridden by a second UR physician.

F. If it is medically contraindicated:

1. An adverse UR finding shall be deemed medically contraindicated unless it is reasonably certain that the resulting transfer is medically safe and in the patient's best interests, and that the proper transfer is suited to the particular needs of the patient;

2. an adverse UR finding resulting in an out-of-facility transfer shall be deemed medically contraindicated unless the patient has voluntarily (i.e., knowingly, willingly and with knowledge of the alternatives) consented to the transfer; provided that transfer within a geographic and operational entity providing both skilled nursing and health related care and services is not an out-of-facility transfer.

(a) Every voluntary consent to transfer shall be accompanied by a dated, written statement: (i) signed by the patient, describing the specific transfer consented to by the patient and reciting that the transfer is voluntary, as defined herein, specifically that he/she understands that transfer will not be required without his/her consent; and (ii) signed by the person designated by the facility or the defendants, certifying that the proposed transfer and available alternatives have been explained to the patient, that the patient understands and voluntarily signed the statement, and that the patient is not unable to consent to the transfer because of confusion or impaired judgment.

(b) If the patient is unable to consent to the transfer because of confusion or impaired judgment, it will be presumed that the patient has not voluntarily consented to the transfer.

III. Patients' procedural rights shall include, but are not limited to, the following items:

A. following adoption or approval of an adverse UR finding, the state or local agency shall provide:

1. timely and adequate written notice of the adverse finding which shall include at least (a) a description of the proposed action, (b) the specific regulations supporting the action, (c) a full explanation of the individual's right to an evidentiary state agency hearing, (d) the procedures for requesting such hearing, (e) the circumstances under which assistance is continued if a hearing is requested, (f) the name, address and phone number where legal services or other representation assistance, if available, may be sought in the patient's locality, (g) a statement of the patient's right of access to his/her records (as described in paragraph E *infra*);

2. a written statement, signed by the UR physician(s) who made the adverse finding, setting forth, in specific detail, the changed medical conditions or other circumstances of the individual which support the adverse finding;

3. a copy of the completed patient assessment form (DMS-1 or form serving the function thereof) used by the UR committee in its review, together with any psychosocial clinical or other addenda.

B. If the adverse finding recommends an out-of-facility transfer (as limited by Section II, F.2, *supra*) the notice described in subparagraph A.1 *supra* shall also include a statement that the transfer cannot be approved or im-

plemented unless the patient voluntarily consents to transfer to a specifically identified facility or facilities or other location.

C. The specific language and form of the notice described in subparagraph A.1 *supra* shall be as agreed to by the parties.

D. A copy of the documents described in paragraph A *supra* shall be provided to the patient, the patient's next of kin or designated representative, the patient's attending physician, and the facility.

E. Every affected patient shall have a fully adequate opportunity, prior to and during the fair hearing, to review an adverse UR finding, to have unencumbered access to, and to review and copy (with the patient permitted to copy without charge a reasonable quantity of documents) the contents of that patient's case file, and all documents and records to be used against the patient at the hearing, all documents, medical or otherwise, which were considered or relied on by the UR committee, and all medical documents and records concerning the patient which are located at the facility where the patient resides, including all so-called "medically contraindicated information" contained in any such documents or records.

IV. Proof of satisfaction of each of the substantive and procedural elements identified in Sections II and III of this decree is a necessary condition for affirmance after hearing of an adverse UR finding. The elements identified in Section II must be proven by testimony at the hearing of a physician or other health professional who participated in making or approving the adverse UR finding and who has knowledge of the facts.

V. To assist facilities and personnel involved in the UR process in the performance of their duties, within 60 days

of the entry of judgment herein defendants shall provide facilities and such personnel with:

A. A UR operations and training manual incorporating all relevant standards and procedures, and

B. a list of adult homes (RCFA's) which are in compliance wtih applicable standards, as determined by the Division of Adult Residential Care of the New York State Department of Social Services (hereinafter "DARC"); no patient may be recommended for discharge to an adult home not on this list without specific waiver from DARC.

VI. The standards and procedures adopted by defendants, which implement the requirements of this decree, shall be promulgated within 60 days of the entry of judgment herein as regulations pursuant to the New York State Administrative Procedure Act to the extent required thereby and unless otherwise indicated herein, and no regulation or procedure shall be promulgated which is inconsistent with this decree.

VII. (This judgment will include provisions to enable adequate monitoring of compliance with the terms of the judgment, the details of which will be agreed upon by the parties prior to submission of the judgment for approval of the Court.)

VIII. Several issues are not resolved by this settlement and are to be disposed of as follows:

A. the following issues are to be resolved by the Court on appropriate motion or hearing:

1. The question of whether there is state action and a constitutional right to a pre-transfer evidentiary hearing in a patient transfer to a higher level of care and/or

a patient transfer initiated by the facility or its agents; and

2. The question of whether, under federal and state law and the Constitution, the State Commissioner of Social Services or the Commissioner's agent may override a hearing officer recommendation in favor of a patient without first having prepared, reviewed, and adequately considered, together with all exhibits, a verbatim transcript of the hearing.

B. Plaintiffs reserve the following issues to be litigated, or, following the period of monitoring described in paragraph VII, *supra,* to be withdrawn without prejudice by plaintiffs:

1. The question of a patient's constitutional right to skilled representatives at state expense (a) at the stage at which the patient is notified of an adverse UR finding and/or is asked to voluntarily agree to transfer, and (b) at a fair hearing to review a UR transfer determination;

2. The question of whether the use of the DMS-1 form and scoring system violates patients' rights; and

3. The question of whether defendants are required to mandate or encourage by reasonable reimbursement incentives, that all facilities provide at least skilled nursing and health related levels of care.

IX. The terms of this judgment shall bind the defendants and their successors in office, their officers, agents, servants, employees and attorneys, and those persons in active concert or participation with them who receive actual notice of this judgment by personal service or otherwise.

X. The issues of the award of reasonable attorneys' fees, costs, and disbursements herein are reserved for later determination by this Court, upon appropriate motion.

XI. Jurisdiction over this suit is retained by this Court until further order (a) for the purpose of enabling any party to apply for an order pursuant to Rule 60 of the Federal Rules of Civil Procedure; (b) for such further orders as may be necessary or appropriate for the continuation, enforcement, or implementation of this judgment or any of the provisions thereof; or (c) for the litigation of issues within the meaning of Section XIII, *infra.*

XII. Except as otherwise provided herein, this judgment shall become effective on the date of entry thereof. All adverse UR findings not implemented by the effective date of this judgment shall be subject to the terms of this judgment.

XIII. Defendants are not bound by and judicial approval of this judgment shall not be sought by the parties until the U. S. Department of Health, Education and Welfare (hereinafter "HEW") represents, or it is judicially determined, that defendants' compliance with this judgment or any portion thereof will not cause federal financial participation (hereinafter "FFP") in the New York State Medicaid Program to be terminated or reduced; except that defendants shall not be bound by this judgment to the extent and during a period that said judicial determination, if any, is judicially stayed or vacated. Any subsequent determination by HEW to terminate or reduce FFP in the New York State Medicaid Program because of defendants' compliance with any part of this judgment shall, upon ten days notice thereof to plaintiffs' counsel, relieve defendants from compliance with that portion of this judgment. In the event that any portion of this judgment is vacated pursuant to this paragraph, plaintiffs shall have the right to litigate in this suit the issues underlying the vacated portion of this judgment.

Dated: New York, New York
May 29, 1979

[Attorneys' subscriptions omitted in printing.]

Attorney for Defendants Attorneys for Plaintiffs

Addendum Concerning Monitoring (to Stipulation of Consent to Entry of Partial Final Judgment)

WHEREAS on May 29, 1979 the attorneys for plaintiffs and defendants in *Yaretsky* v. *Blum,* Civil Action No. 76 Civ. 3360 (S.D.N.Y.), entered into a Stipulation of Consent to Entry of Partial Final Judgment (hereinafter "Judgment");

WHEREAS, paragraph VII of said Judgment stated that "this judgment will include provisions to enable adequate monitoring of compliance with the terms of the judgment, the details of which will be agreed upon by the parties prior to submission of the judgment for approval of the Court"; and

WHEREAS, the parties have agreed to submit said Judgment for approval by the Court on October 17, 1979;

WHEREFORE, IT IS STIPULATED AND AGREED by and between the parties herein, through their respective attorneys, that in order to monitor compliance with said Judgment:

A. Defendants shall obtain, maintain and tabulate

1. data stating the number of adverse UR findings, broken down by:

a. region

b. type of facility (i.e. single or multi-level)

c. recommended level-of-care destination

d. disposition or outcome of the finding, including the number resulting in:

(1) adverse findings which were overridden by defendants or their agent,

(2) transfers which were accepted voluntarily,

(3) transfers which were not accepted voluntarily,

(4) "fair hearing" affirmances,

(5) "fair hearing" reversals.

2. data regarding conformance with the requirements of Section II of the Judgment.

B. Defendants shall provide plaintiffs with the data tabulated pursuant to paragraph A, and any other data compiled or tabulated by defendants in connection with adverse UR findings, at periodic intervals not to exceed four months.

C. Defendants shall maintain copies of every written statement executed pursuant to Section II F.2(a) of the Judgment and every notice of adverse UR finding, with required addenda, provided pursuant to Section III.A., of the Judgment.

D. Entry by the Court of this Judgment shall confirm the right of plaintiffs and/or their designees to have access, at reasonable times and places, and solely for the purposes of the instant lawsuit, to all:

1. data or documents obtained, maintained or tabulated by defendants in connection with adverse UR findings;

2. agents or employees of defendants involved in the operation or monitoring of the UR procedures described in this judgment;

3. patients who are subject to adverse UR findings, as well as said patients':

a. families,

b. facilities,

c. facility staff,

d. physicians,

e. medical and other records.

E. Defendants shall provide plaintiffs or their designees with letters-of-introduction to facilitate access to persons, places and documents described in paragraph D, *supra,* and shall take any other reasonable steps within their authority necessary to facilitate said access, but shall not have any other obligation in connection therewith.

F. Defendants shall have the right to disapprove, upon reasonable grounds, a person or organization chosen by plaintiffs as their designee for purposes of the within monitoring provisions.

G. The within monitoring provisions shall take effect six months from the date that the Judgment is entered, or upon request of plaintiffs, whichever is later, and shall continue for one year thereafter, except that said provisions shall in no event continue in effect for more than eighteen months following implementation by defendants of the terms of the Judgment.

DATED: New York, New York
October 17, 1979.

[Attorneys' subscriptions omitted in printing.]

Attorney for Defendants

Attorneys for Plaintiffs

October 17, 1979 Memorandum Opinion Endorsed[*]

The court holds that as to both non-UR transfers out of a facility or to a lower level of care and as to UR transfers to higher levels of care there is a due process right to a hearing, state action being involved in both instances for all of the reason [sic] set forth in plaintiffs [sic] memorandums [sic] of law on these question [sic] and that it is settled law that a verbatim transcript is required.

Submit Order.

N.Y. N.Y. 10/17/79

s/ CONSTANCE BAKER MOTLEY
U.S.D.J.

Filed Oct. 19, 1979
U.S. District Court
S.D. of N.Y.

---

[*] Handwritten endorsement by the district judge on the back of document number 82 of the record on appeal.—ED.

December 13, 1979 Partial Final Judgment

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
Civil Action No. 76 Civ. 3360 (CBM)

WILLIAM YARETSKY, *et al.*,

Plaintiffs,

and

MARY FOLEY, *et al.*,

Plaintiffs-Intervenors

—against—

BARBARA BLUM, et al.,

Defendants.

The Court on October 17, 1979 having ordered the entry as a partial final judgment of the consent stipulation signed by attorneys for the parties on May 29, 1979 together with the Addendum Concerning Monitoring signed on October 17, 1979, and several legal issues having been reserved in the partial final judgment for judicial determination, and the Court having issued a memorandum opinion on October 17, 1979, granting summary judgment in favor of the plaintiffs on the reserved legal issues, it is hereby

ORDERED, ADJUDGED and DECREED (1), pursuant to Rule 23(c)(1) of the Federal Rules of Civil Procedure, that the plaintiff class in this action is defined as all Medicaid recipients in the State of New York who are residents

of skilled nursing facilities or health-related facilities in the State; and it is further,

ORDERED, ADJUDGED and DECREED (2), pursuant to Rule 56 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2201, that the defendants' failure to provide advance adequate notice in writing and the opportunity for a prior evidentiary hearing for each plaintiff class member whom the nursing facility in which he/she resides intends to discharge, transfer to a lower level of nursing care, or transfer to a higher level of nursing care is unlawful under the Due Process Clause of the Fourteenth Amendment; and it is further,

ORDERED, ADJUDGED and DECREED (3), pursuant to Rule 56 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, that the action of the defendant State Commissioner of Social Services and her authorized agent in rendering a fair hearing decision unfavorable to a plaintiff class member without first obtaining, reading, and adequately considering a verbatim transcript of the fair hearing, together with all exhibits at the hearing, is unlawful under the Due Process Clause of the Fourteenth Amendment and New York State Law; and it is further,

ORDERED AND ADJUDGED (4), pursuant to Rule 65 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, that the defendants, their officers, agents, employees, successors in office and all persons in active concert and participation with them (including all skilled nursing and health-related facilities in New York State) be and hereby are permanently enjoined, in the case of any plaintiff class member, from permitting or taking the action of discharging the patient, transferring the patient to a lower level of nursing care, or transferring the patient to a higher level of nursing care without the provision by the

defendants or their authorized employees of (a) written notice to the affected patient a reasonable period in advance of the proposed action setting forth in adequate detail at least a description of the proposed action and a full explanation of the individual's right to obtain a prior evidentiary state agency hearing to contest the proposed action, and (b) the opportunity for the affected patient to have an evidentiary state agency hearing in advance of the proposed action on the issue of the validity and appropriateness of the proposed action pursuant to applicable federal and state statutory and regulatory provisions (including, but not limited to, 42 C.F.R. §§ 405.1121 (k)(4) and 442.311 (c)); and it is further,

ORDERED and ADJUDGED (5), pursuant to Rule 65 of the Federal Rules of Civil Procedure and 28 U.S.C. § 2202, that the defendant State Commissioner of Social Services, her officers, agents, employees, and successors in office be and hereby are permanently enjoined from rendering a fair hearing decision unfavorable to any plaintiff class member without first obtaining, reading, and adequately considering a verbatim transcript of the fair hearing, together with all exhibits at the hearing; and it is further,

ORDERED (6) that the issue of plaintiffs' entitlement to an award of reasonable attorneys' fees, expenses, and costs herein is reserved for later determination by this Court, upon appropriate motion.

s/ CONSTANCE BAKER MOTLEY
U.S.D.J.

Dated: New York, New York
December 13, 1979

JUDGMENT ENTERED 2/19/80
s/ RAYMOND F. BURGHARDT
Clerk

Notice of Appeal

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK

[Title omitted in printing.]

SIRS:

PLEASE TAKE NOTICE that defendant BARBARA BLUM, Commissioner of the New York State Department of Social Services and defendant ROBERT WHALEN, Commissioner of the New York State Department of Health hereby appeal to the United States Court of Appeals for the Second Circuit from each and every part of the partial final judgment entered on the 14th day of February, 1980 granting summary judgment in favor of the plaintiffs on the reserved legal issues.

Dated: New York, New York
March 6, 1980

Yours, etc.,

[Attorney's subscription and address omitted in printing.]

Attorney for Defendants

[Attorneys' names and addresses omitted in printing.]

Attorneys for Plaintiffs
Filed Mar. 7, 1980
U.S. District Court
S.D. of N.Y.

August 25, 1980 Opinion of the United States Court of Appeals

UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

No. 1234—September Term, 1979
(Argued June 11, 1980 Decided August 25, 1980)
Docket No. 80-7197

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Plaintiffs-Appellees,

—and—

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY, and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors-Appellants [sic],

—against—

BARBARA BLUM, individually and as Acting Commissioner of the New York State Department of Social Services; ROBERT WHALEN, M.D., individually and as Commissioner of the New York State Department of Health,

Defendants-Appellants.

Before:

LUMBARD and MANSFIELD, *Circuit Judges*, and MEHRTENS, *District Judge.**

---

* Pursuant to § 0.14 of the Rules of this Court, this appeal is being determined by Judges Lumbard and Mansfield, who are in agreement on this opinion. Judge Mehrtens, Senior District Judge for the Southern District of Florida who was designated to sit on this case and who heard the argument, unfortunately died on July 16, 1980. Although he concurred in the disposition of this case, prior to his death he did not have the opportunity to see this opinion.

Appeal from a permanent injunction granted by the District Court for the Southern District, Motley, *J.*, requiring the State of New York to furnish certain procedural safeguards to Medicaid recipients resident in nursing homes prior to transfer. Affirmed in part, vacated in part, and modified.

[Appearances omitted in printing.]

LUMBARD, *Circuit Judge:*

Plaintiffs, certified by the district court as that class of persons receiving New York State Medicaid assistance who are residents of nursing homes, were granted a permanent injunction by the District Court for the Southern District, Motley, *J.*, enjoining state authorities and nursing homes from discharging or transferring patients to a different level of care without certain procedural safeguards intended to supplement residents' existing state statutory right of a hearing.[1] Also at issue is the district court's permanent injunction forbidding state officials from reversing a hearing officer decision favorable to a plaintiff class member without having considered the full transcript of the hearing, and the district court's refusal to order the Department of Health, Education and Welfare ("HEW") joined as a party. We affirm the permanent injunction with respect to the due process rights of patients subject to transfer, with some modification; we vacate the district court's injunction with regard to reversals of hearing officer determinations; and we affirm the district court with respect to its refusal to order joinder of HEW.

---

[1] At the evidentiary hearing, the patient can challenge his transfer on various substantive grounds derived from state and federal statute and regulations. The most important of these substantive grounds is that his transfer be for "medical reasons".

In the past two decades, government has taken responsibility for caring for the medical needs of the elderly. One result of this has been the creation of a system of nursing homes, owned and run by private individuals or charitable organizations, whose population is made up largely of elderly recipients of state and federal assistance. Nursing homes are classified into two types: skilled nursing facilities (SNF's), and health related facilities (HRF's).[2] The latter provide a lower level of care than the former.

Through HEW regulations, the federal government mandates a procedure called Utilization Review (UR), a kind of patient audit meant to insure that patients are not kept in SNF's longer than necessary, or in any facility when they no longer need medical attention or custodial care. The regulations provide that decisions on such matters are to be made by a Utilization Review Committee (URC), made up, in part, of physicians not financially interested in the affairs of the particular nursing home.

When a patient is transferred from one level of care to another, the State Medicaid authorities review his status and reduce or increase his benefits accordingly and the parties agree that reimbursement rates are "ordinarily" lower for HRF's than for SNF's. A decision to reduce or terminate a patient's Medicaid benefits triggers a federal right (under 42 U.S.C. § 1396(a)(3) and 45 C.F.R. § 205.10) to a hearing, provided by the state. Plaintiffs claimed in this case that the bare right to such a hearing did not meet the requirements of due process, in part because of inherent shortcomings and in part because of the manner in which the state has performed its duty to provide such hearings.

---

[2] At the time this case was tried, there were approximately 95,000 nursing home beds in New York state, including approximately 68,000 SNF beds and 27,000 HRF beds. There were 611 nursing homes in the state, of which 291 were SNF's, 30 were HRF's, and 290 were combination SNF-HRF's.

In particular the district court found that patients were not given effective written notice of their hearing rights and were not given sufficient access to their medical files to enable them effectively to challenge the transfer decision.

In an earlier appeal, we affirmed, insofar as appealed from, a preliminary injunction granted by the district court ordering certain additional procedural due process safeguards with regard to nursing home transfers, prohibiting the state from delegating to nursing homes the responsibility for notifying patients of their hearing rights, and prohibiting the state from not dsclosing to the patient medical information deemed harmful to a patient. *Yaretsky v. Blum,* 592 F.2d 65 (2d Cir. 1979).

Before the injunction was made permanent, the parties entered into a consent judgment which embodied most of the procedural safeguards sought by plaintiffs with respect to patient transfers. The consent judgment spelled out the right of the patient or his representative to receive timely notice of the intended transfer; guaranteed the opportunity to have access to all documents in his medical file; made the patient's voluntary permission a prerequisite to transfer; and required that the hearing officer consider a "psycho-social" evaluation of the effect of transfer on the patient.

The consent judgment left several issues of the law to be decided by the district court: (1) are due process protections required (a) when a patient is transferred from a lower to a higher level of care, whether the transfer is initiated by a URC or not, and (b) when a patient transfer to a lower level of care is not initiated by a URC; and (2) are state administrative agency decision-makers required by due process or state law to read a verbatim transcript of the hearing before reversing a hearing officer's determination favorable to a member of the plaintiff class?

The district court found that patients are entitled to due process when transferred from a lower level of care

to a higher one, and when a transfer is initiated by someone other than a URC. We agree because we think such transfers involve state action affecting constitutionally protected property and liberty interests.

The Supreme Court has not defined the limits of state action, but it has supplied the following, somewhat sibylline formula: "the existence of 'state action' depends on 'whether there is sufficiently close nexus between the State and challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself.'" *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974), *quoted in Schlein v. Milford Hospital Inc.*, 561 F.2d 427, 428 (2d Cir. 1977). In *Jackson*, the inaction of a state regulatory commission in failing to veto a clause in a utility's tariff was found insufficient to be state action. In *Schlein*, the action of a private hospital in rejecting a physician's application for staff privileges was held not to be state action.

In the case at bar, however, the state takes a less passive role and responds to the "action" of the "regulated entity". When a nursing home moves a patient from an SNF to an HRF, or when a patient is moved by either the nursing home or a URC to an SNF from an HRF, the state Medicaid authorities adjust the patient's benefits. The state has, in essence, delegated a decision to increase or reduce a public assistance recipient's benefits to a "private" party; but such a delegation cannot prevent due process guarantees from attaching. In *Yaretsky v. Blum*, *supra* at 67, we held that the state cannot delegate its due process duty to notify patients of their rights to a hearing.

Appellants argue that when a patient's private physician initiates a transfer of his patient from one level of care to another that cannot be said to be state action. This argument misses the mark, because we do not base our finding of state action on the character of the nursing home in-

dustry as a regulated industry, nor on the function of providing health care for the elderly as a non-delegable duty of the state. A private physician's decision to transfer his patient can have the same result as a nursing home's—an alteration in the patient's benefits. Since that is the nexus required by *Jackson v. Metropolitan Edison,* and since that exists equally despite the change in identity of the party initiating the transfer, no exception can be made for physician-initiated transfers.

Once it is determined that state action has occurred, the second level of analysis is the identification of a liberty or property interest affected by the state action. In *O'Bannon v. Town Court Nursing Home,* 48 U.S.L.W. 4842 (1980), seven justices agreed that nursing home patients did not enjoy a due process right with respect to a decision by HEW to decertify a nursing home. But the *O'Bannon* majority also clearly recognized due process protection for Medicaid patients when the withdrawal of "direct benefits" under Medicaid programs was involved. 48 U.S.L.W. at 4845. These "direct benefits" were characterized by the court as those "essentially financial in character." Thus, in this case, when a patient is transferred from an SNF to an HRF, or from either an SNF or HRF to an adult home providing no medical care, or is simply discharged, a clear property right entitled to constitutional protection is affected. Where a patient is transferred to a higher level of care, there is no similar withdrawal of "essentially financial" "direct benefits." But appellees argue that a patient's interest in avoiding the effects of "transfer trauma" is a constitutionally protected "liberty interest." We agree.

In *O'Bannon v. Town Court Nursing Home,* the majority assumed that "transfer trauma" existed, but reasoned that when such trauma was caused by the action of a third party (i.e., the nursing home) in failing to remain qualified for federal aid, Medicaid recipients did

not suffer a "direct" enough injury to make it a deprivation of life, liberty or property. 48 U.S.L.W. at 4845. We do not believe, however, that *O'Bannon* forecloses the question whether there is a liberty interest in avoidance of transfer trauma in this case. The majority's distinction between those rights of Medicaid recipients which are protected by due process ("direct benefits") and those not so protected ("indirect benefits"), in the context of which the majority's rejection of reliance on transfer trauma as denial of a liberty interest occurs, is prefaced by the important qualification: "decertification . . . is not the same for purposes of due process analysis as a decision to transfer a particular patient. . . ." 48 U.S.L.W. at 4845. Moreover, *O'Bannon* was not decided on the basis of a record that included much detailed information about the existence of transfer trauma, see 48 U.S.L.W. at 4849, n.10 (Blackmun, *J.*, concurring in the judgment), although one justice, relying on extra-record studies, was convinced that the medical evidence was "inconclusive." 48 U.S.L.W. at 4850 (Blackmun, *J.*, concurring in the judgment). We note that the record in this case contains ample evidence that transfer of elderly patients, even when it does not pose an increased risk of mortality, carries with it the undeniable possibility of emotional and psychological harm—at least in the case of many individuals. To us this does not seem any less a "liberty interest" than a prison inmate's interest in not being transferred from a penitentiary to a psychiatric hospital; which interest was accorded constitutional protection in *Vitek v. Jones*, 48 U.S.L.W. 4317 (1980).

Having found that state action and a constitutionally cognizable liberty or property interest exists, it follows that the plaintiffs are entitled to due process. But the question of what process is due them requires further

consideration, particularly where, as here, plaintiffs are already given, by statute, the right to a hearing. *Mathews v. Eldridge,* 424 U.S. 319 (1976), requires a balancing of private interest, risk of erroneous decision, and administrative burdens in formulating the procedural protection required to satisfy due process. We are persuaded that the contours of the relief fashioned by the district court represent an appropriate balancing of the interests recognized in *Mathews.* In essence, the injunction confirms those due process protections already conferred on Medicaid patients by the language of federal and state statutes and regulations already on the books. Under such circumstances, and absent any argument by appellants that the scope of the remedy is too broad, we affirm the district court's injunction under *Mathews.*[3]

Appellants also argue that the district court's refusal to order an appearance by HEW in this case was an abuse of discretion. Since New York State's eligibility for federal funds reimbursing many of the costs of its Medicaid program depends on HEW's determination that state procedures comply with federal regulations, appellants argue that implementation of the court's injunction may jeopardize New York's approved status. Given such a threat, they argue, HEW should have been brought into the case. Whatever the desirability of such participation, see *Yaretsky v. Blum, supra* at 70 (Lumbard, *J.*, concurring in part, dissenting in part), we cannot say that the district court abused its discretion. Present in the record in this case is a letter from HEW acknowledging

---

[3] We note that the October 17, 1979 partial final judgment embodying the parties' consent agreement contains procedural protections for patients subject to UR-initiated transfer considerably more extensive than those granted to patients subject to non-UR transfer under the partial final judgment of February 19, 1980. Only the latter has been appealed, and thus we have no occasion to deal with whether or not the protections embodied in the October 17 stipulations are required by due process or satisfy the principles of *Mathews v. Eldridge, supra.*

that the post-injunction state of affairs poses no compliance problem for HEW. However, we think it best to modify the injunction to include a provision that if at any time in the future HEW determines that the procedures mandated by this injunction make New York State wholly or partially ineligible for Medicaid reimbursement funds, upon application, the district court shall vacate the injunction.

Finally we reach the question of the district court's decision that a decision-maker's failure to rely on hearing transcripts violates the Fourteenth Amendment of the United States Constitution and New York law. We hold that neither the Constitution nor New York law requires the administrative decision-maker in an appeal from a hearing officer recommendation to read (or listen to) the entire transcript (or tape recording) of the hearing before issuing an administratively final decision, whether favorable or adverse to the claimant. Accordingly, we vacate the district court's injunction insofar as it affected the state's administrative practice in this regard.

Patients about to be transferred have the right, under federal statute and regulations, 42 U.S.C. § 1396(a)(3) and 45 C.F.R. § 205.10, to a "fair hearing" provided by the state. This hearing is conducted by a hearing examiner who listens to the testimony, prepares a summary, and makes a recommendation to the Commissioner. Although the parties sharply disagree as to whether or not the hearing officer is empowered to make findings of fact, we do not find that issue controlling and do not decide it. The parties agree that the stenographic or electronic transcript of the hearing is sent to the Department of Social Services in Albany, and that the Commissioner's designees who are responsible for deciding the case do not listen to a tape of the hearing, and that no transcript of the hearing is made prior to their

decision. (The chief purpose of the state statutory requirement that a complete electronic or stenographic record of the hearing be kept appears to be to allow judicial review in a proceeding under N.Y.C.P.L.R. Article 78.) The Commissioner's designees follow a set of ten detailed criteria in deciding whether to approve or disapprove the hearing officer's recommendation. If he feels the need, the designee may consult the electronic or stenographic record, but the parties agree that state policy does not require the designee to do so.

We believe that, insofar as federal law is concerned, this issue is governed by *National Nutritional Foods Assoc. v. FDA*, 491 F.2d 1141 (2d Cir. 1974). In *National Nutritional*, an FDA regulation was challenged on the ground that the Commissioner who signed the order involved could not possibly have reviewed and considered objections to the proposed rule because of their volume during the short period he had been in office at the time he approved the regulation. Like appellees in this case, petitioners in *National Nutritional* relied on *Morgan v. United States*, 298 U.S. 468 (1936) (Morgan I), which contains the familiar phrase "The one who decides must hear." *Id.* at 481. But, as Judge Friendly's opinion in *National Nutritional* observes, "the life of this aspect of Morgan I was extremely brief. In Morgan IV [*United States v. Morgan*, 313 U.S. 409 (1941)] Mr. Justice Frankfurter, writing for a Court unanimous on this point, took back most or all of what the first decision had given." 491 F.2d at 1144.

Even the Morgan I case cannot be said to go as far as appellees would argue. As Professor Kenneth Culp Davis has written:

> Since the only purpose of sifting and analyzing of evidence by subordinates is to save the time of the deciding officers, this necessarily means that deciding officers may "consider and appraise" the evidence by reading a summary or analysis prepared by sub-

> ordinates. The Supreme Court thus did not require in the First Morgan case that deciding officers must read all the evidence or even that they must directly read any of it. The requirement has to do with personal understanding of the evidence, not with the mechanics by which the understanding is developed. In common practice, deciding officers develop their understanding of evidence not only through reports of subordinates but especially through summaries and explanations in briefs. . . .

2 Davis, Administrative Law § 11.03 at 44-45 (1958) (footnotes omitted). See also *Bates v. Sponberg*, 547 F.2d 325 (6th Cir. 1976) (no violation of due process when decision-making body voted on appeal from an administrative adjudication without reading the transcript, relying on summary report).

Under Morgan IV and *National Nutritional*,[4] an administrative official to whom a decision has been delegated is immune from judicial inquiry "as to the extent of his investigation and knowledge of the points decided, or as to the methods by which he reached his determination."[5]

---

[4] In *National Nutritional*, our opinion emphasized that the "presumption of regularity" in the actions of administrative decision-makers is especially appropriate 'in the context of the promulgation of legislative rules as distinguished from adjudication," 491 F.2d at 1145. The resolution of appeals in nursing home transfer cases is, of course, administrative action of an adjudicative rather than rule-making type. We see, however, no reason for adopting a different rule in the adjudicative context. Under *Mathews v. Eldridge, supra*, the administrative burden on the state may be given weight in determining the boundaries of due process protection in both adjudicative and rule-making proceedings; indeed, *Mathews* itself involved an adjudication. *Bates v. Sponberg*, 547 F.2d 325 (6th Cir. 1976) also involved an adjudication.

[5] An exception to this general principle exists where there is a showing of misconduct on the part of the agency. *See, e.g., Singer Sewing Machine Co. v. NLRB*, 329 F.2d 200, 206-08 (4th Cir. 1964).

National Nutritional, supra, 491 F.2d at 1145, quoting *DeCambra v. Rogers,* 189 U.S. 119, 122 (1903). The reasons for this rule derive from the extended, complex nature of the administrative decision-making process, *see Citizens to Preserve Overton Park, Inc. v. Volpe,* 401 U.S. 402, 422-23 (1971) (Blackmun, *J.*, concurring), the difficulty of seeing into the decision-maker's mind, and the enormous volume of administrative decisions which must be made each year. Although, for example, only about 600 appeals from nursing home transfer cases are decided each year in New York State, approximately 68,000 appeals in welfare benefit adjustment cases must be decided in the same period in New York. Such a large administrative burden is an important factor in determining what kind of due process protection must be accorded the subjects of administrative decision-making. *Mathews* v. *Eldridge,* 424 U.S. 319, 335 (1976).[6]

Appellees also argue that New York law prohibits the administrative practice at issue, citing *La Valle v. Blum,* 67 A.D.2d 708 (App. Div. 2d Dept. 1979), *Anderson v. Toia,* 59 A.D.2d 1024 (App. Div. 4th Dept. 1977), *Halley v. Lavine,* 47 A.D.2d 945 (2d Dept. 1975), *Cruz v. Lavine,* 45 A.D.2d 720 (App. Div. 2d Dept. 1974). Some of these intermediate appellate memorandum opinions are distinguishable on their facts; for example, in *Anderson, supra,* the fatal defect in administrative procedure seems

---

[6] Appellees rely also on *Ostrowski v. City of New York,* 601 F.2d 629 (2d Cir. 1979), which involved a due process challenge to the decision-making procedures used by the Department of Sanitation in disciplinary cases. But the remarks we made concerning federal due process issues raised by the Department's practices in *Ostrowski* were dictum, since the case was remanded for findings on state law issues. In any event, as the *Ostrowski* opinion notes, the decision-maker in that case "did not have a complete record of hearing." *Id.* at 631. As noted above, the decision-makers in nursing home transfer cases have available to them the complete record of the hearing.

to have been the fact that "the recording tape ran out" during the recording of the hearing, rather than that the agency decision-maker failed to listen to the tape. And *La Valle v. Blum, supra,* is most fairly read as standing for the principle that where an agency determination rests on certain facts which are incorrect and which can be found in correct form in a transcript unread by a decision-maker, a court will grant relief under N.Y.C.P.L.R. Art. 78. But *Halley v. Lavine, supra,* does unequivocally hold that administrative decision-makers must hear or read verbatim transcripts or recordings of fair hearings. *Accord, Cruz v. Lavine, supra.* Whether these memorandum decisions represent a developing trend among New York's intermediate appellate courts is something the future will reveal.

Appellants argue that controlling decisions of the New York Court of Appeals unequivocally show that there is no state law requirement that decision-makers read transcripts, whatever the status of lower court decisions possibly in conflict with the Court of Appeals cases. The first of these cases, *Matter of Weekes v. O'Connell,* 304 N.Y. 259, 107 N.E.2d 290 (Ct. App. 1952), offers little support to appellants. In *Weekes,* the State Liquor Authority adopted and affirmed a hearing officer's decision in a license revocation case within an hour of the conclusion of the hearing, before the hearing had been transcribed. The Court of Appeals, in an opinion by Chief Judge Fuld, held the Authority's decision invalid. Seven years later, however, in *Matter of Taub v. Pirnie,* 3 N.Y.2d 188, 144 N.E.2d 3 (Ct. App. 1957), the Court of Appeals, again in an opinion by Chief Judge Fuld, limited *Weekes'* significance. *Taub* involved a challenge to a decision by a Zoning Appeals board based on the fact that one member of the board had voted without reading a transcript of the hearing held in the case. Judge Fuld wrote:

> Courts, we have said, will not " 'probe the mental process' " of the members of an administrative

> tribunal. Absent a showing, "clearly reveal[ed]," that "they made no independent appraisal and reached no independent conclusion," we will not disturb the decision. As we wrote in the *Weekes* case, "the extent to which independent study of the evidence in the record is necessary to the required exercise of informed judgment must be left to the wisdom and practical good sense of the commissioners themselves" . . . .

3 N.Y.2d at 193-94.

In the Court of Appeals' most recent case in this series, *Matter of Wallace v. Murphy,* 21 N.Y.2d 433, 235 N.E.2d 759 (Ct. App. 1968), involving disciplinary action against a police officer, the Court reiterated its adherence to the *Taub* doctrine that what is required by law (absent specific statutory provisions requiring more) is only an informed decision, and confirmed *Taub's* interpretation of *Weekes* as resting on the Liquor Authority's violation of its own rules and regulations. *Id.* at 438. *Wallace* further held that where state law requires a full transcript to be made, that transcript must be "available" to the decision-maker. But *Wallace* does not hold, and we think the implication is fair that it holds to the contrary, that the decision-maker must take advantage of the transcript's availability in any manner more specific than that required to satisfy *Taub's* mandate of an exercise of "informed judgment".

The Department of Social Services' present practices, as the parties have stipulated, clearly comport with state law requirements that administrative decision-making be an exercise of "informed judgment." The use of the detailed criteria followed by the Department indicate that the decision-maker does much more than rubber-stamp the hearing officer recommendation, and his reliance on summaries and other material prepared by the hearing officer satisfies the state law requirement that his judgment be

informed. Moreover, it is clear that *Wallace's* requirement that where transcripts exist they be available to the decision-maker is satisfied by the Department's practices. The parties have agreed that the electronic recordings of the hearings are forwarded to the Department in Albany, where the decision-maker works. The Department's policy is to have its decision-makers review the electronic transcript only if they feel it would be useful. This practice establishes that the decision-makers have the transcripts "available" in the sense required by *Wallace*.

Accordingly, we reject appellees' argument that state law requires administrative decision-makers to read or listen to complete transcriptions or recordings of hearings before reversing hearing officer recommendations favorable to recipients of benefits conferred by the state.

Affirmed in part, vacated in part, and modified.

February 18, 1981 Order of the United States Court of Appeals Denying Rehearing

UNITED STATES COURT OF APPEALS
SECOND CIRCUIT

At a stated term of the United States Court of Appeals, in and for the Second Circuit, held at the United States Court House, in the City of New York, on the 18th day of February, one thousand nine hundred and eighty-one.

UNITED STATES COURT OF APPEALS
Filed
Feb 18 1981
A. Daniel Fusaro, Clerk
Second Circuit
No. 80-7197

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Plaintiff-Appellees,

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Plaintiffs-Intervenors-Appellees,

v.

BARBARA BLUM, individually and as Acting Commissioner of the New York State Department of Social Services, ROBERT WHALEN, M.D., individually and as Commissioner of the New York State Department of Health,

Defendants-Appellants.

Order Denying Rehearing

A petition for rehearing containing a suggestion that the action be reheard in banc having been filed herein by counsel for the defendants-appellants, Barbara Blum, et al.

Upon consideration by the panel that heard the appeal, it is

Ordered that said petition for rehearing is DENIED.

It is further noted that the suggestion for rehearing in banc has been transmitted to the judges of the court in regular active service and to any other judge on the panel that heard the appeal and that no such judge has requested that a vote be taken thereon.

/s/ A. Daniel Fusaro
Clerk

NO. 80-1952

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

Office-Supreme Court, U.S.
FILED
JUN 18 1981
ALEXANDER L. STEVAS,
CLERK

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, as Commissioner of the New York State Department of Health,

Petitioners,

-against-

WILLIAM YARETSKY, RALPH CUEVAS and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOF, PAULINE ASHKENAZY, CADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMNA, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

PLAINTIFFS' BRIEF IN OPPOSITION TO DEFENDANTS' PETITION FOR A WRIT OF CERTIORARI

KALMAN FINKEL
Attorney-in-Charge
The Legal Aid Society
Civil Division

JOHN E. KIRKLIN
Director of Litigation
Civil Appeals & Law Reform Unit
The Legal Aid Society
11 Park Place-8th Floor
New York, New York 10007
(212) 227-2755

DAVID GOLDFARB
The Legal Aid Society
953 Southern Blvd.
Bronx, New York 10459

CHARLES ROBERT
91 North Franklin Street
Room 205
Hempstead, New York 11550

Attorneys for Plaintiffs-
Respondents

TABLE OF CONTENTS

Page

STATEMENT OF THE CASE.....1

SUMMARY OF ARGUMENT.....9

ARGUMENT.....12

THE PETITION FOR A WRIT OF CERTIORARI SHOULD BE DENIED BECAUSE (A) THE SECOND CIRCUIT CORRECTLY CONCLUDED THAT THE FOURTEENTH AMENDMENT'S DUE PROCESS CLAUSE REQUIRES NOTICE AND THE OPPORTUNITY FOR AN EVIDENTIARY HEARING BEFORE NURSING FACILITIES CAN TRANSFER OR DISCHARGE MEDICAID PATIENTS, AND (B) DEFENDANTS' AMBIVALENCE CONCERNING THE JUSTICIABILITY OF THE CASE AND PLAINTIFFS' ABILITY TO AVOID ADVERSE FACILITY ACTION MAKES THIS AN ESPECIALLY INAPPROPRIATE CASE FOR CERTIORARI REVIEW.....12

A. State Action.....15

1. State Adjustment of Medicaid Benefits and Governmental obligation to Make Medicaid Decisions.....15

2. State's Obligation to Care for Institutionalized Elderly Persons.....19

3. Government Regulation.....20

B. Due Process-Protected Interests....23

CONCLUSION.....26

APPENDIX A--Letters from Richard Ruid.....1a

APPENDIX B--Letter from Anthony Maddaloni.....5a

TABLE OF AUTHORITIES

CASES — Page

Adickes v. Kress & Co., 398 U.S. 144 (1970).....16

Barrett v. United Hospital, 376 F.Supp. 791 (SDNY 1974).....16

Brede v. Director for Dept. of Health, 616 F.2d 407 (9 Cir. 1980).....23

Burchette v. Dumpson, 387 F.Supp. 812 (EDNY 1974).....25

Dennis v. Sparks, ___U.S.___, 66 L.Ed.2d 185 (1980).....16

Flagg Brothers v. Brooks, 436 U.S. 149 (1978).....17

Fuentes v. Shevin, 407 U.S. 67 (1972).....17

Goldberg v. Kelly, 397 U.S. 254 (1970).....23

Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974).....16

Joy v. Daniels, 479 F.2d 1236 (4 Cir. 1973).....22

Kane v. Perry, 41 NY2d 1051 (1977).....13

Lopez v. Phipps Plaza South, 498 F.2d 937 (2 Cir. 1974).....22

Matter of Lee v. Smith, 43 NY2d 453 (1977).....19

North Georgia Finishing, Inc. v. Di-Chem, Inc., 419 U.S. 601 (1975).....17

O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980).....8,12,21,22,23,24

Perez v. Sugarman, 499 F.2d 761 (2 Cir. 1974).....20

Public Utilities Commission v. Pollack, 343 U.S. 451 (1952).....16

CASES — Pages

Roberson v. Wood, 464 F.Supp. 983 (E.D. Ill. 1979).....16,23

Schlein v. Milford Hospital, Inc., 561 F.2d 427 (2 Cir. 1977).....16

Sniadach v. Family Finance Corp., 395 U.S. 337 (1969).....17

Tucker v. Toia, 43 NY2d 1 (1977).....19

Vitek v. Jones, 445 U.S. 480 (1980).....14,23,25

Yaretsky v. Blum, 456 F.Supp. 653 (SDNY 1978).....2

Yaretsky v. Blum, 592 F.2d 65 (2 Cir. 1979).....2,12,17

Yaretsky v. Blum, 629 F.2d 817 (2 Cir. 1980).....6,7,8

FEDERAL STATUTES

42 USC §1395x.....21,22

42 USC §1396 et seq. 17,19,21,24

STATE CONSTITUTION AND STATUTES

NYS Constitution, Article 17.....19

NYS Public Health Law §2800 et seq..18,19,20,23

NYS Social Services Law §62.....19

FEDERAL REGULATIONS

42 CFR §400 et seq 12,13,17,19,21,22

42 CFR §405.1121(K)(4).....6,21

42 CFR §442.311(C).....6,21

45 CFR §100 et seq. 21

STATE REGULATIONS

10 NYCRR §400 et seq..... 20,23

10 NYCRR §414.14(a)(4).....6,21

10 NYCRR §700 et seq.....13,20

18 NYCRR §358.....13,18

18 NYCRR §500 et seq.....17

No. 80

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, as Commissioner of the New York State Department of Health,

Petitioners,

-against-

WILLIAM YARETSKY, RALPH CUEVAS and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

PLAINTIFFS' BRIEF IN OPPOSITION TO DEFENDANTS' PETITION FOR A WRIT OF CERTIORARI

STATEMENT OF THE CASE

The certified plaintiff class in this action consists of "all Medicaid recipients in the State of New York who are residents of skilled nursing facilities or health-related facilities in the State." Partial final judgment of District Court, dated Decmeber 13, 1979. Following the granting of a preliminary injunction and

partial summary judgment for the plaintiffs,* extensive pre-trial discovery and trial preparation by the plaintiffs, and a stipulation between the parties concerning relevant facts and legal issues, the parties entered into a consent agreement which resolved favorably for plaintiffs many of the issues in the suit.** The consent agreement was approved by the District Court as a partial final

---

* In an unreported decision issued in January, 1978, the District Court initially certified the class and granted a preliminary injunction on several procedural issues concerning a Medicaid patients right (a) to receive timely and adequate written notice, with a detailed statement of reasons, from the State or local Department of Social Services following an adverse Utilization Review Committee (URC) determination that the patient no longer needed his current level of care and should be transferred or discharged out of the facility, and (b) to have full and unencumbered access to all documents and medical information, including so-called "medically contraindicated" information, prior to the "fair hearing" to review the adverse URC determination. That preliminary injunction, insofar as appealed from, was affirmed by the Second Circuit Court of Appeals. 592 F.2d 65 (1979). Partial summary judgment was also granted to plaintiffs with respect to certain rule-making requirements of the New York State Administrative Procedure Act. 456 F.Supp. 653 (1978).

** The consent agreement prohibits the approval or implementation of an adverse URC determination without receipt and consideration by the UR Committee of a written psycho-social evaluation, the attending physician's written statement describing the advisability of the proposed transfer and the patient's likely reaction to it, and a written discharge plan identifying the proposed new placement in sufficient detail to meet the particular needs of the patient. An adverse URC determination cannot be approved or implemented if there is any internal inconsistency, error, or uncorrected procedural or technical irregularity in the assessment instrument or other document forming a basis for the determination. Further, an adverse UR determination cannot be approved or implemented unless it is found to be medically safe and appropriate and in the best interests of the patient, and unless the patient has voluntarily and knowingly consented in writing to the transfer out of his facility. The consent judgment also confirms the patient's procedural rights in connection with the rendering of an adverse URC determination and its review by fair hearing, including the procedural rights secured earlier in the litigation on plaintiffs' preliminary injunction motion. Proof of satisfaction of all the above requirements for an adverse URC determination and testimony at the hearing by a health professional with knowledge of the facts and the determination is required as a necessary condition for a fair hearing decision affirming an adverse URC determination.

judgment on October 19, 1979, following written representations from the Regional Office of the Department of Health and Human Services ("HHS") that the defendants' compliance with the terms of the agreement would not result in retroactive termination or reduction of federal financial participation in the State Medicaid Program. As agreed between the parties, the consent judgment also provided that the defendants would be relieved from their obligations under any provision thereof if HHS determined to terminate or reduce federal financial participation in the State Medicaid Program because of defendants' compliance with that provision.

In explaining their willingness to enter into the consent agreement, the defendants, through their attorney, stated to the Court as follows:

> Defendants agreed to the inclusion of the provision regarding the necessity of patient consent to transfer for two reasons. First, there exists a widespread phenomena known as "transfer trauma" which is the anxiety experienced by an elderly patient when moved from or even faced with the threat of being moved from a nursing home which he has come to view as his home to another institution. Further, it appears that transfer trauma can cause a deterioration of the patient's health leading in some cases to his death. Secondly, it appears that there is at present no way to know which patients who object to being transferred out of a facility will suffer from transfer trauma and which will not.
>
> Therefore, the State defendants concluded that, given the current state of medical understanding of transfer trauma, the only way to protect the patient's health is to require that he consent to any proposed out-of-facility transfer.

Affidavit of Assistant Attorney General Kenneth A. Thomas, sworn to September 19, 1979.

By the time the parties were close to accord on the submission to the District Court of the consent agreement, several cases had been brought to the attention of plaintiffs' attorneys in which members of the plaintiff class had been threatened by their facilities, outside of the utilization review (UR) process, with involuntary transfer or discharge or with denial of readmission following temporary hospital stays. Plaintiffs also anticipated a significant increase in the number of facility-initiated transfers once the UR route to the expulsion of troublesome or undesireable patients was effectively closed by the consent agreement.

In the joint pre-trial order prepared by the parties and approved by the District Court in March, 1979, the parties stipulated to the defendants' policies and practices concerning facility-initiated actions to discharge a patient or transfer him to a lower level of care, without a URC determination, or to transfer a patient to a higher level of care, with or without a URC determination. Defendants stipulated (¶60) that a patient had no right to prior notice and hearing in the case of a facility-initiated discharge or transfer to a lower level of care, but that if the patient requested a URC determination and was able to obtain it, he was entitled to prior notice and fair hearing review of that determination. Defendants further stated that they were considering stopping URC determinations in that context. No notice was to be afforded to patients subjected to such facility-initiated transfers that URC determinations were available, and no indication was given that the patient who knew enough to request a URC determination would necessarily get one or that, if provided, it would supersede the facility decision.

Defendants also stipulated (¶'s 57, 59(c)) that a patient had no right to prior notice and hearing in the case of a facility-initiated transfer to a higher level of care, and that if a URC determination were obtained by the patient upon request (a policy also under reconsideration) the patient had no right to a fair hearing to review that determination. Defendants stated (¶56) that a URC determination that the patient should receive a higher level of care was "advisory" only, and that the patient's refusal to comply would not result in termination of his Medicaid payments. However, no notice of the "advisory" nature of such a URC determination was to be afforded the patient, and in a policy memorandum issued in June, 1978 (78 ADM-31, Addendum page 1) the defendants stated that in such a case the transfer to a higher level of care should be "arranged" by the facility "as soon as possible." Defendants further stipulated (¶58) that it was their practice prior to July, 1978 to afford fair hearing review of adverse UR determinations recommending transfer to a higher level of care, that approximately 10 hearings were held on such transfer decisions with approximately 5 reversals on the merits, and that from July-September, 1978 defendants inadvertently rendered a few hearing decisions on the merits of such transfer decisions.

Finally, defendants stipulated in the pre-trial order (pp.17,23) that one of the issues for trial in this case was whether plaintiffs had a right under federal or state law or the Constitution to an evidentiary hearing prior to a facility-initiated discharge or transfer to a lower level of care, without a URC determination, or to a higher level of care, with or without a URC determination. Subsequently, when the consent agreement was submitted for the District Court's approval, defendants specifically stipulated to the reservation for determination by the District Court of "[t]he question of whether there is state action and a constitutional right to a pre-transfer evidentiary hearing in a patient

transfer to a higher level of care and/or a patient transfer initiated by the facility or its agents."*

Following briefing and argument by the parties on the issue, the District Court ruled that state action is involved in a facility-initiated discharge of a Medicaid patient or his transfer to a lower level of care, done without a UR determination, and in a facility-initiated transfer of a patient to a higher level of care, done with or without a UR determination, and concluded therefore that due process required that the defendants provide advance notice and the opportunity for a hearing to a patient threatened with such a discharge or transfer. That ruling was embodied in a partial final judgment requiring the defendants, in cases of proposed facility-initiated transfers or discharges, to provide affected patients with prior notice and the opportunity for an evidentiary hearing at which they can contest the validity and appropriateness of the proposed action under federal and state regulations which permit facility-initiated transfers or discharges only for medical reasons, the welfare of the patient or other residents, or non-payment for his stay. (42 C.F.R. §§405.1121(K)(4), 442.311(C); 10 N.Y.C.R.R. §414.14(a)(4)).

---

* Also reserved for judicial determination was the question of whether federal or state law or the Constitution required the State Commissioner of Social Services to read and consider a verbatim transcript of the fair hearing before rendering a decision adverse to a Medicaid nursing patient. The Second Circuit reversed the District Court's decision favorable to the plaintiffs on that issue. 629 F.2d 817 (1981). The plaintiffs' petition for a writ of certiorari to review that decision was denied by this Court on February 23, 1981.

Between the time of the District Court's decision and argument in the Second Circuit, plaintiffs' attorneys were informed of several cases in which members of the plaintiff class were threatened with facility-initiated transfers or discharges which were avoided only through the intervention of legal services attorneys or persons associated with the New York City nursing home ombudsman program. In response to questions from the Court, plaintiffs' attorney informed the Second Circuit of these circumstances during oral argument of the appeal.

On appeal, the Second Circuit affirmed the judgment on these issues, with some modification, concluding that the facility-initiated transfers and discharges "involve state action affecting constitutionally protected property and liberty interests." 629 F.2d 817, 820 (1981). The Court found state action to inhere in the State's adjustment of the patient's Medicaid benefits following the facility-initiated discharge or transfer to a lower or higher level of care (either with or without a URC determination), noting that "[t]he state has, in essence, delegated a decision to increase or reduce a public assistance recipient's benefits to a 'private' party." 629 F.2d at 820. The Court indicated that in its state action finding it did not need to rely on plaintiffs' additional arguments concerning "the character of the nursing home industry as a regulated industry, nor on the function of providing health care for the elderly as a non-delegable duty of the state." 629 F.2d at 821.* The Court found that a Medicaid patient has a due process-protected property interest in his current level of Medicaid benefits, the termination or reduction of which accompanies the

* The Second Circuit also did not reach plaintiffs' claim made there and in the District Court that federal and state regulations independently require notice and a hearing in connection with facility-initiated patient transfer and discharge actions.

facility's action to discharge the patient or transfer him to a lower level of care. A due process-protected liberty interest, the Court concluded, inheres in the patient's interest in avoiding the transfer trauma which the record in this case disclosed attends the involuntary transfer of an elderly and infirm nursing patient to a higher or lower level of care. 629 F.2d at 821. Therefore, the Court concluded, the Fourteenth Amendment's Due Process Clause applies and requires adequate notice and the opportunity for an evidentiary hearing before the implementation of the facility action.* The Court, however, modified the injunction below to include a provision requiring it to be vacated if HHS determines that the State's compliance therewith makes the State wholly or partially ineligible for federal Medicaid funds.**

At no point in either the District Court or the Second Circuit did defendants suggest that the issues concerning facility-initiated transfer and discharge were non-justiciable or that patients threatened with such actions could secure the protections of the consent judgment by obtaining URC determinations upon request.

---

* The Second Circuit distinguished this Court's decision in O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980), by noting that the Medicaid nursing patients in this case are subjected to "direct" injury and loss of Medicaid benefits as a result of the challenged state-sanctioned action of the facilities, whereas in O'Bannon the injury and loss of benefits were only the "indirect" result of the challenged decertification of the facility.

** In the separate cross-petition for a writ of certiorari accompanying this brief, plaintiffs ask this Court to review the propriety of and reverse that modification of the District Court's injunction if this Court grants the defendants' petition.

Developments subsequent to the decision of the Second Circuit confirm that the issues decided by that court represent a continuing controversy between the parties. On December 31, 1980 defendants' attorney sent to plaintiffs' attorney two letters, dated December 18, 1980, from Richard Ruid, Senior Social Services Program Specialist of the New York State Department of Social Services, directing local Departments of Social Services to afford fair hearing rights to two identified class members--Ewell Perry and Gilberta Kaman--who were threatened with facility-initiated transfers. / See Appendix A. Further, the letters in no way suggested that these patients could secure the benefits of the consent judgment by receiving, on request, URC determinations in their cases. Plaintiffs' attorneys also have received a copy of a letter dated April 27, 1981 from Anthony Maddaloni, Health Program Administrator in the Bureau of Long-Term Care Services of the New York State Department of Health, to a nursing facility administrator which indicates that a patient threatened with a facility-initiated discharge is entitled to a URC determination only if the facility order happens to correspond with the date that the URC is required to review the patient's need for continued stay. See Appendix B.

SUMMARY OF ARGUMENT

The defendants' petition for a writ of certiorari should be denied because, under the decisions of this Court, the District Court and the Second Circuit were clearly correct in their resolution of the issues presented in this case, and because defendants' dramatic inconstancy concerning the justiciability of the case and concerning basic facts about plaintiff class members' rights under the consent judgment in this case make it a particularly inappropriate case for this Court to review.

The state action decisions of this Court plainly support the conclusion of the Second Circuit that state action, for purposes of the Fourteenth Amendment's Due Process Clause, attaches to the action of a nursing facility in discharging a Medicaid patient or transferring him to a lower or higher level of care when the State correspondingly modifies the patient's Medicaid benefits on the basis of the facility action. That state action finding as well inheres in (a) the extensive governmental funding, regulation, and control of nursing facilities, including the federal and state regulations which specifically limit facility-initiated transfers to particular stated grounds; and (b) the nursing facility's exercise, as an agent of the State, of the inherently public or governmental function in New York State of providing care for old, infirm, and indigent adults who are eligible for Medicaid benefits. Finally, applicable federal and state regulations independently require notice and hearing in connection with facility-initiated discharges and transfers.

The Second Circuit's finding that Medicaid patients have due process-protected property and liberty interests in avoiding facility discharges and transfers to lower or higher levels of care is also firmly supported by this Court's decisions. As the Second Circuit found, the State's termination or reduction of a patient's Medicaid benefits when the facility discharges the patient or transfers him to a lower level of care implicates protected property interests. Also, Medicaid patients who are discharged or transferred to lower or higher levels of care by a facility have protected property and liberty interests rooted in federal and state regulations which specifically prohibit all such actions except "for medical reasons, or for his welfare or that of other patients, or for nonpayment for his stay."

Thus, the only possibly controversial aspect of the Second Circuit's rulings in this case--that a patient's interest in avoiding the transfer trauma that is triggered by an involuntary facility discharge or transfer is a liberty interest protected by the Due Process Clause--is wholly unnecessary to the conclusion that both state action and due process-protected property and liberty interests are involved in facility discharges and transfers to both lower and higher levels of care. Nonetheless, the Second Circuit correctly found on this record that such transfer trauma--the existence, severity, and unpredictability of which the defendants had expressly conceded below--is entitled to constitutional protection.

Finally, the dramatic shifts in defendants' position that are reflected in their petition to this Court make this a particularly inappropriate case for certiorari review. Defendants expressly stipulated to the adjudication by the District Court of the issues presented here and at no time in either the District Court or the Second Circuit made the suggestion, that they assert for the first time here, that there was no justiciable controversy between the parties. Also defendants now suggest for the first time that plaintiff class members can avoid facility-initiated discharges or transfers by securing URC determinations automatically upon request and thereby obtaining the protections of the consent judgment in this case. These half-hearted attempts by defendants to disavow in this Court the admissions and concessions that they made consistently throughout this litigation in the courts below underscore the inappropriateness of certiorari review in this case.

ARGUMENT

THE PETITION FOR A WRIT OF CERTIORARI SHOULD BE DENIED BECAUSE (A) THE SECOND CIRCUIT CORRECTLY CONCLUDED THAT THE FOURTEENTH AMENDMENT'S DUE PROCESS CLAUSE REQUIRES NOTICE AND THE OPPORTUNITY FOR AN EVIDENTIARY HEARING BEFORE NURSING FACILITIES CAN TRANSFER OR DISCHARGE MEDICAID PATIENTS, AND (B) DEFENDANTS' AMBIVALENCE CONCERNING THE JUSTICIABILITY OF THE CASE AND PLAINTIFFS' ABILITY TO AVOID ADVERSE FACILITY ACTION MAKES THIS AN ESPECIALLY INAPPROPRIATE CASE FOR CERTIORARI REVIEW.

Plaintiffs respectfully submit that this Court should deny the petition for a writ of certiorari in this case because the Second Circuit's findings of state action and due process-protected property and liberty interests in facility discharges and transfers are plainly consistent with this Court's prior decisions.* Further, defendants' arguments, made here here for the first time, that there was no justiciable

* Plaintiffs argued in both the District Court and the Court of Appeals, and continue to assert in this Court, that applicable federal and state regulations independently require notice and hearing in connection with facility-initiated discharges and tranfers. When a facility initiates a Medicaid patient's discharge or transfer to a lower level of nursing care and the State Department of Social Services correspondingly terminates or reduces the patient's Medicaid benefits, applicable federal and state regulations plainly require that the State provide the patient with prior notice and the opportunity for an agency hearing. 42 C.F.R. §431.220(a)(2) mandates that the State "must grant an opportunity for a hearing to. . .[a]ny recipient who requests it [after appropriate notice] because he believes the agency has taken an action erroneously." "Action," in turn, is defined as a "termination, suspension or reduction of Medicaid eligibility or covered services." 42 C.F.R. §431.201. Accord, O'Bannon v. Town Court Nursing Center, 447 U.S. 773, 65 L.Ed. 2d 506, 515n. 10, 519 n. 19 (1980). The defendants are obligated to comply with, and may not delegate to a private entity, these notice and hearing requirements of the federal regulations, as a necessary condition to participation in the Medicaid program. Cf. Yaretsky v. Blum, 592 F.2d 65, 67 (2d Cir. 1979). The principle that the State agency is required to provide a hearing for a Medicaid patient whose benefits the State terminates or reduces because of the decision of a nominally private doctor is

Ftnote cont.

controversy between the parties and that patients can avoid the facility action by triggering the patient protections of the consent judgment in this case are plainly wrong and place this case in such a confusing posture as to make it inappropriate for certiorari review.*

Ftnote cont.

hardly novel. Thus, 42 C.F.R. §431.213(f) and 18 N.Y.C.R.R. §358.8 require an agency hearing in cases where a "change in the level of medical care is prescribed by the recipient's physician."

Regulations of the State Departments of Social Services and Health equally require agency notice and the opportunity for a hearing in connection with a facility-initiated discharge or transfer which triggers a corresponding termination or reduction of the patient's Medicaid benefits. 18 N.Y.C.R.R. §358.4(a)(4) and (6) entitle a Medicaid recipient to a hearing on the grounds of "discontinuance or suspension of assistance, in whole or in part" and on "any other grounds affecting the. . .recipient's entitlement to assistance or the amount thereof." Cf. 18 N.Y.C.R.R §358.8(d)(1)(viii) (right to State fair hearing when change in level of medical care is prescribed by recipient's physician.) 10 N.Y.C.R.R. §730.17(c) provides for the patient's "right to appeal a negative. . . continued stay review decision." The New York Court of Appeals has confirmed the right of Medicaid patients under state regulations to obtain a State fair hearing where the effect of non-State action is to require the transfer of the patients out of their nursing facilities and to terminate or reduce their benefits. Kane v. Perry, 41 N.Y.2d 1051 (1977), reversing on opinion at Special Term (82 Misc. 2d 1019) and dissenting opinion at Appellate Division (55 Ad2d 678).

* There is no merit to defendants' assertion that this case does not present a justiciable controversy, assertedly because no identified class member was subjected to or threatened with a facility-initiated transfer or because an affected patient might obtain a URC determination and thereby secure the benefits of the consent judgment. As indicated earlier in this brief, at page 4, plaintiffs attorneys knew by the time the consent agreement was approved of the cases of several class members who had been threatened with facility-initiated transfers or discharges. Further, defendants stipulated in the pre-trial order to their policies and practices concerning facility-initiated transfers and discharges and agreed to the trial of the issue of the legality of such actions without prior notice and an opportunity for a

Ftnote cont.

fnote cont.

hearing. These stipulations contained an implicit concession that such facility-initiated actions were occurring and an explicit admission that facility-initiated transfers to higher levels of care, accompanied by URC determinations, were in fact occurring. In the consent agreement itself defendants expressly stipulated that the District Court should adjudicate the issue of the notice and hearing requirements in connection with facility-initiated transfers and discharges. Defendants made no argument in either the District Court or the Second Circuit that this issue was non-justiciable. Since the time of the District Court's decision, plaintiffs' attorneys were made aware of several additional cases of facility decisions to transfer or dicharge plaintiff class members, including two cases specifically identified in letters written by one of defendants' employees.

Defendants never suggested in the District Court or the Second Circuit, or in any of their official policy memoranda issued in connection with this case, that patients threatened with facility-initiated transfers or discharges could secure the protections of the consent judgment by obtaining URC determinations upon request. Further, very recent correspondence from one of defendants' employees confirms that URC determinations are not routinely available to patients threatened with facility-initiated discharges or transfers.

Under these circumstances it is plain that there was and remains a justiciable controversy between the parties on these issues. Cf. Vitek v. Jones, 445 U.S. 480, 485-7 (1980). It is utterly disingenuous and unavailing for defendants to suggest for the first time in this Court, in light of the stipulations and concessions made below, that this case is moot.

A. State Action

In the District Court and the Second Circuit, plaintiffs argued that the state action requirement of the Fourteenth Amendment's Due Process Clause was satisfied under several state action tests approved by this Court, whether considered separately or in the aggregate: (1) under the "nexus" test, since the State encourages, adopts, and acts upon the facility's decision to transfer or discharge the patient, by adjusting the patient's Medicaid benefits accordingly; (2) under the "symbiotic relationship" test, since the interests of the State and the facilities are so interwined by way of governmental regulation, funding, and control that the State must be recognized as a "joint participant" in the facility action; and (3) under the "public function" doctrine, since the rendering of decisions upon which the adjustment of public assistance benefits is based and the provision of institutional care for aged, infirm and indigent adults are functions which are traditionally the ultimate responsibility of government.

1. State Adjustment of Medicaid Benefits and Governmental obligation to Make Medicaid Decisions

Probably the most compelling evidence of state action, and the basis for the Second Circuit's state action finding here, is the fact that the State Department of Social Services terminates, reduces, or increases the patient's Medicaid benefits on the basis of the facility's discharge, transfer to a lower level of care, or transfer to a higher level of care of the patient. Thus the State is not merely aiding, encouraging, and connoting approval of the nominally private facility transfer or discharge decision; beyond that, the State is adopting that decision as the basis for the purely governmental action of adjusting the patient's Medi-

caid benefits. This is state action, not inaction, concerning the very activity about which the plaintiff patients are complaining. Accord, Roberson v. Wood, 464 F.Supp. 983 (E.D.Ill. 1979). Cf. Public Utilities Commission v. Pollack, 343 U.S. 451 (1952). Thus, as the Second Circuit observed, this case is sharply distinguished from the cases relied on by defendants, where what was objected to was the State's failure to act and its mere acquescence in the activities of the private entity. Contrast Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974) (no state action in passive inaction of Pennsylvania Public Service Commission in simply failing to reject the termination clause of the utility tariff); Schlein v. Milford Hospital, Inc., 561 F.2d 427 (2d Cir. 1977)(no State participation in Hospital's denial of staff privileges to doctor); Barrett v. United Hospital, 376 F.Supp. 791 (S.D.N.Y. 1974), aff'd mem., 506 F.2d 1395 (2d Cir. 1974)(no State participation in Hospital's denial of staff privileges). The State's adjustment of the patient's Medicaid benefits on the basis of the facility's transfer or discharge decision makes for a strong nexus and joint partnership arrangement between the action of the State and that of the facility.* Cf. Adickes v. Kress & Co., 398 U.S. 144 (1970); Dennis v. Sparks, ___ U.S. ____, 66 L.Ed.2d 185 (1980).

It is difficult to imagine a more clearly public and governmental function than responsibility for the decision upon which the adjustment of public assistance benefits is based. The government's responsibility for the reduction

---

* The defendants' disingenuous characterization of these facility actions as "medical" decisions is belied by the fact that they are equally likely to represent the facility director's distinctly non-medical determination to rid himself of a patient who is too troublesome or costly to keep and whom he seeks to replace with a more cooperative, private-paying patient.

or termination of governmental public assistance benefits involves discretionary and policy-making judgments which are inherently governmental and non-delegable to a private party. However, even if, as asserted by defendants, that function did involve mere ministerial action, such "overt official involvement" in the otherwise nominally private facility transfer or discharge action would supply the necessary state action. Flagg Brothers v. Brooks, 436 U.S. 149, 157 (1978). Thus, this Court has repeatedly found that the automatic ministerial acts of court clerks in issuing attachment or replevin orders are sufficient to confer state action on otherwise purely private activities. North Georgia Finishing, Inc. v. Di-Chem, Inc., 419 U.S. 601 (1975); Fuentes v. Shevin, 407 U.S. 67 (1972); Sniadach v. Family Finance Corp., 395 U.S. 337 (1969).

Federal and state statutory and regulatory provisions buttress the conclusion that the function of rendering final decisions upon which the adjustment of the patient's Medicaid benefits is based is an exclusively government function. 42 U.S.C. §1396a(a)(5) requires the state or local government agency to make determinations of Medicaid eligibility. Federal regulations generally forbid delegation of responsibilities lodged with the State Medicaid agency, 42 C.F.R. §431.10(e), and specifically require that the state or local agency make Medicaid eligibility decisions. 42 C.F.R. §§431.10(c) and 431.11(d). Cf. Yaretsky v. Blum, 592 F.2d 65, 67 (2 Cir. 1979). State statutory and regulatory requirements equally mandate that the government ultimately be responsible for the correctness of level of care decisions upon which the adjustment of Medicaid benefits is contingent. 18 NYCRR §505.9(b)(1) and (2) require the prior approval of the defendant Commissioner of Health for all admissions to skilled nursing and health-related facilities, including those resulting from transfers, based on a "properly completed and scored" long-term care placement form. New York Public Health Law

§2803(1)(d) requires the defendant State Commissioner of Health or his designee to "determine the necessity and appropriateness of care and services" provided Medicaid patients by hospitals, defined to include nursing facilities (§2801(1)). Under §2803(1)(d) the State Department of Social Services is not authorized to make Medicaid payments for care and services unless the Department of Health certifies them to be appropriate to the patients' needs. 18 NYCRR §§358.9(a) and (b) require the local social services official to review any proposed action to modify benefits "to determine its correctness" before sending notice of proposed agency action.

Additional governmental involvement in a facility's decision to transfer a Medicaid patient to a higher level of care occurs when there is simultaneously a recommendation of the UR Committee that such a transfer be made. Although defendants characterize that UR determination as "advisory" only, there can be no question that the UR determination sanctions and strongly encourages the facility to transfer the patient. Further, the patient is not given notice that the UR determination is "advisory" only and that his Medicaid eligibility will not be jeopardized if he refuses to go. It is disingenuous at best for the defendants to attach significance to the patient's theoretical "choice" to refuse to leave the facility, since in reality the facility can simply evict the patient over his objections,* with a corresponding State adjustment of Medicaid benefits. The action of the UR Committee in recommending the patient's transfer to a higher level of care is clearly governmental action, since federal statute and regulations make it plain that the Committee is acting as an agent of the State in discharging

* In reality, facilities have an even greater incentive to evict patients who, it is claimed, require more care (and are thus more expensive to care for) than those who allegedly require transfer to a lower facility (and are thus cheaper to care for).

its duty to review the medical needs of nursing patients. 42 U.S.C. §§1396(a)(26) (1979 Supp.), 1396a(a)(30), 1396a(a)(31), 1396b(g)(1)(c) and (D). 42 C.F.R. §456.1(a) and (b); 456.301(a), 456.401(a) and (b).

2. State's Obligation to Care for Institutionalized Elderly Persons

It is settled that in New York State the provision of care--including institutionalized care--for old, infirm, and indigent adults who qualify for Medicaid benefits is inherently a public or governmental function. Article 17, §1, of the New York State Constitution states that

> [T]he aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means, as the legislature may from time to time determine.

Article 17, §3, of the Constitution provides further that

> [T]he protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine.

The New York Court of Appeals has made clear the fundamental governmental commitment represented by the constitutional provision at Article 17, §1. Since the provision of assistance to the needy is "specifically mandated by our Constitution," it is "not a matter of legislature grace," but rather is a "fundamental part of the social contract" and imposes upon the State an "affirmative duty to aid the needy." Tucker v. Toia, 43 N.Y.2d 1, 7, 8 (1977). Accord, Matter of Lee v. Smith, 43 N.Y.2d 453, 460 (1977). The State Social Services Law (§62 (1), (2) (5)(b), (5)(d)) makes local welfare districts, as agents of the State, responsible for the assistance and care, including nursing care, of any resident who is in need of public assistance and care which he is unable to provide for himself. Under Article 28 of the State Public Health Law, the State acts through licensed and regulated private nursing facilities to directly perform the

governmental function of providing nursing care for the medically needy.

These provisions of New York State law clearly suffice to establish that the responsibility for the well-being of elderly medicaid patients in nursing facitilities is a public or governmental function sufficient to establish state action in the narrow context of the discharge or transfer of those patients from their facilities. Cf. Perez v. Sugarman, 499 F.2d 761 (2 Cir. 1974), state action finding reaffirmed, Duchesne v. Sugarman, 566 F.2d 817, 822 n.4 (2 Cir. 1977)(state action found under the public function, as well as the symbiotic relationship test in the detention of a child by a private child-care agency, in light of the ultimate statutory responsibility of the State for the care and well-being of neglected children, as exercised through the private agencies).

3. Governmental Regulation

The governmental regulation, funding and control of nursing facilities and the medical review and transfer processes are comprehensive. No nursing home can operate in New York State without an operating certificate from the New York State Department of Health. New York Public Health Law, Article 28. The State maintains a strict limit on the number of such operating certificates and the number of beds which may operate in any one community, and it requires aplicants to demonstrate the public need for such beds or facilities. Id., §§2802, 2805. In addition, all nursing homes operate under a pervasive system of Health Department Regulations (10 NYCRR §§414 et seq., 730 et seq, 740 et seq) supplemented by frequent Health Facilities Memoranda and other directives which govern, in minute detail, every aspect of nursing home operations, from the frequency of linen changes to the protection of patient rights (§§414.14, 415.1). The most important of these detailed governmental regulations are the express limitations imposed by federal and state law on

the facility's transfer or discharge of the patient "only for medical reasons, or for his welfare or that of other patients, or for nonpayment for his stay." 42 C.F.R. §§405. 1121(K)(4); 442.311(C); 10 NYCRR §414.14(a)(4). See O'Bannon v. Town Court Nursing Center, supra, 65 L.Ed 2d at 514 n.9,

Moreover, under the Medicaid program, the state contracts with qualified providers for the rendering of services to Medicaid patients and the providers are then reimbursed by the state out of joint federal-state funds. 42 U.S.C. §1396a(a)(13)(E). Determinations of Medicaid eligibility are made by the state or local Department of Services. 42 U.S.C. §1396a(a)(5). The administrative and supervisory functions of the State Department of Social Services are nondelegable. 45 C.F.R. §104.100(b)(1) and (b)(3). The State Department must insure that the medical assistance provided is equal in "amount, duration. . .[and] scope" for all eligible recipients. 42 U.S.C. §1396(10)(B) and (C). The State Department of Social Services must provide for a regular program of medical review and medical evaluation of each Medicaid patient's needs for skilled nursing services. 42 U.S.C. §1396a(a)(26); 42 C.F.R. §456.4. All skilled nursing facilities receiving federal payments under Title XIX must satisfy the extensive requirements of federal law. 42 U.S.C. §§1396a(a)(28); 1395x(j). The Department must provide for utilization review in order to safeguard against inappropriate utilization of care and services. 42 U.S.C. §§1396a(a)(30), 1396b(g)(1)(c), 1396(i)(4). There must be a regular program of medical evaluation of each patient's needs for intermediate care services. 42 U.S.C. §1396a(a)(31); 42 C.F.R. 456.4 The State Department of Health is responsible for assuring the review of the "appropriateness and quality of care and services" furnished to Medicaid recipeints. 42 U.S.C. §1396a(a)(33)(A); 42 C.F.R. §456.6(a).

Skilled nursing facility services are defined and described in the federal statute and regulations. 42 U.S.C. §1396d(f); 42 C.F.R. §§440.40-.140, 442.202, 456.609(a)(2), 405.125-.128a, 405.133, 405.1124(b) and (c), 405.1130, 405.1131. Intermediate care facility services are also defined and described in the federal statute and regulations. 42 U.S.C. §1396d(c), 42 C.F.R. §440.150, 442.251(a)(2), 456.609(a)(2). The obligation of each skilled nursing facility to have an independent utilization review program, the composition of the utilization review committees, and the description of the UR process are set forth in detail in the federal statute and regulations. 42 U.S.C. §§1395x(j), (k); 42 C.F.R. §405.1121(d), 405.1137, 456.501(b), 456.300-.345. The utilization review process for intermediate care facilities is similarly detailed in the federal regulations. 42 C.F.R. §§456.406, 456.436-.438.

Finally, as plaintiffs argued below, what is at stake here is not only the discontinuance of a patient's nursing care accompanied by the State's modification of his Medicaid benefits, but, as well, the eviction of the patient from his home. Cf. O'Bannon v. Town Court Nursing Center, supra,65 L.Ed.2d at 522 (Justice Blackmun, concurring). This eviction is accomplished, as demonstrated above, by a facility which is heavily subsidized, regulated, and controlled by the government and which is subject to federal and state governmental regulations specifically circumscribing the permissible grounds for eviction. This quantum of governmental involvement is at least comparable to that which has persuaded lower courts to find governmental action and due process protections in a low-income tenant's eviction by a private landlord from governmentally subidized §236 housing. Lopez v. Phipps Plaza South, 498 F2d 937 (2 Cir. 1974); Joy v. Daniels, 479 F2d 1236 (4 Cir. 1973).

B. Due Process-Protected Interests

Medicaid nursing patients have both property and liberty interests protected by the Fourteenth Amendment's Due Process Clause in avoiding facility-initiated discharges or transfers to lower or higher levels of care, with corresponding adjustment of their Medicaid benefits. First, the Second Circuit correctly concluded, and it has been settled law since Goldberg v. Kelly, 397 U.S. 254 (1970), that the State's termination or reduction of public assistance Medicaid benefits which accompanies a facility-initiated discharge or transfer to a lower level of care implicates a property interest protected by due process. As this Court observed in O'Bannon v. Town Court Nursing Center, supra, 65 L.Ed.2d at 519, "[t]he Government cannot withdraw these direct benefits without giving the patients notice and an opportunity for a hearing on the issue of their eligibility for benefits." Second, as plaintiffs argued in both the District Court and the Second Circuit, Medicaid patients subjected to facility-initiated discharges or transfers to a lower or higher level of care have due process protected property and liberty interests rooted in both federal and state law not to be discharged or transferred except "for medical reasons, or for his welfare or that of other patients, or for nonpayment for his stay." 42 C.F.R. §§405.112(K)(4), 442.311(C); 10 N.Y.C.R.R. §414.14(a)(4). Accord, O'Bannon v. Town Court Nursing Center, supra, 65 L.Ed 2d at 514 n.9; Brede v. Director for Dept. of Health, 616 F.2d 407, 410-11 (9 Cir. 1980); Roberson v. Wood, 464 F.Supp. 983 (E.D. Ill. 1979). Cf. Vitek v. Jones, 445 U.S. 480 (1980). Additional due process-protected interests in avoiding facility-initiated discharge or transfer to a lower or higher level of care inhere in the patient's right under state law "to refuse medication and treatment after being fully informed of and understanding the consequences of such actions" (N.Y. Public Health Law, §2803-c(3)(e); 10 N.Y.C.R.R. §414.14(a)

(3)), and under federal law in choosing from among qualified providers the particular facility at which to receive medical care and services (42 U.S.C. §1396a(a)(23)). Accord, O'Bannon v. Town Court Nursing Center, supra, 65 L.Ed.2d at 518.

Thus, the findings of the District Court and the Second Circuit that Medicaid patients have due process-protected interests in avoiding facility discharges and transfers to both lower and higher levels of care are sustainable with reference to federal and state positive law sources, without the need to reach the question of whether, on the record in this case, patients have a due process-protected liberty interest in avoiding the "transfer trauma" which accompanies involuntary transfer out of his facility. Nonetheless, plaintiffs submit that the Second Circuit corretly concluded, on this record and in the context of a "decision to transfer a particular patient . . .based on his individual needs" (O'Bannon v. Town Court Nursing Center, supra, 65 L.Ed.2d at 518), that the patient who is involuntarily transferred to a higher level of care is threatened with transfer trauma that implicates a liberty interest protected by the Due Process Clause.

Defendants specifically admitted in the District Court that the transfer trauma experienced by a Medicaid nursing patient who is subjected to or even threatened by involuntary transfer from his facility is a "widespread phenomenon" which is unpredictable in its impact and "can cause a deterioration of the patient's health leading in

some cases to his death." See this brief at page 3, supra.* Further, many of the patients who are discharged or transferred by their facilities end up in adult homes, which, as conceded by defendants, are not medical facilities, are not permitted to provide medical or nursing services, sometimes mix elderly patients with ex-mental patients and alcoholics, and are not equiped to handle a large range of patient impairments and needs. (Joint Pre-Trial Order, ¶8).

The patient's interest in being free of such trauma, deterioration of health, and threat of death accompanying involuntary movement from their facility should enjoy, as the Second Circuit observed, the same due process protection that was accorded in Vitek v. Jones, 445 U.S. 480 (1980), to a prison inmate's interest in avoiding the harm of transfer from a penitentiary to a psychiatric hospital.

* Cf. Burchette v. Dumpson, 387 F.Supp. 812, 819 (E.D.N.Y. 1974) ("The damage which may result from such transfers is irreparable in the true sense of the word. Changes in surroundings and movement of long distances of senior citizens who are suffering from physical and psychological infirmities are likely to aggravate their condition and increase the likelihood of death." As indicated by the administrator of a New York City nursing facility in his deposition in this case, the trauma of being transferred to a higher level of care comes largely from the patient's fear that the move means that he might be dying. Deposition of David Glaser, at pages 47-48.

CONCLUSION

For the foregoing reasons, plaintiffs respectfully request that defendants' petition for a writ of certiorari be denied.

Dated: New York, New York
June 17, 1981

Respectfully submitted,

KALMAN FINKEL
Attorney-in-Charge
The Legal Aid Society
Civil Division

JOHN E. KIRKLIN
Director of Litigation
Civil Appeals & Law Reform Unit
The Legal Aid Society
11 Park Place - 8th Floor
New York, New York 10007
(212) 227-2755

DAVID GOLDFARB
The Legal Aid Society
953 Southern Blvd.
Bronx, New York 10459

CHARLES ROBERT
91 North Franklin Street
Room 205
Hempstead, New York 11550

Attorneys for Plaintiffs-Respondents

RECEIVED
DEC22 1980

December 18, 1980

RECEIVED
DEC22 1980
COUNSEL
N. Y. STATE DEPT OF
SOCIAL SERVICES

Westchester County Department
of Social Services
Nursing Home Unit
150 Grand St.
White Plains, NY 10601

Dear Nursing Home Liason:

We have been informed by the Office of Health Systems Management White Plains regional office that a residential health care facility patient who is a Westchester County Medical Assistance recipient has been recommended for transfer by his attending physician. We are now required to notify this patient of his right to a fair hearing. This letter presents the recommended procedure for fair hearing notification in these instances. The recipient is Ewell Derry, MA D 072435019 at The Ruth Taylor Institute.

The additional fair hearing notification requirement is as a result of the latest court order in the Yaretsky v. Blum case. Medical Assistance recipients in RHCFs who are determined to require a higher or lower level of nursing care regardless of whether the proposed transfer is based on a decision by the utilization review committee, attending physician, or facility medical director are now entitled to a fair hearing. It should be noted that while we are under a court order to implement this procedure, the order is being appealed and finalized procedures in the form of an Administrative Directive will not be issued until the Court of Appeals makes its final determination. While these fair hearings will normally deal only with medicaid level of care determinations which are ultimately the responsibility of the Office of Health Systems Management and not the local Department of Social Services, we are under an obligation to offer the recipient a fair hearing.

Facilities will continue to follow the procedures that are specified in Health Facilities Memorandum 80-27 (4/15/80), and 80-ADM-12 (2/29/80) if the utilization review committee determines (based upon a continued stay review) that a patient/resident requires transfer to a lower level of care. However, all other cases involving proposed transfer to a higher or lower level of care fall under the procedures contained in this letter. This latest court order does not effect direct transfers from residential health care facilities to hospitals.

When the utilization review committee recommends transfer to a higher level of care or when the attending physician or facility medical director recommend transfer to a higher or lower level of care, the residential health care facility must notify the patient/resident, attending physician, next of kin or sponsor and the responsible local department of Social services. This notification will contain the name and address of the attending physician, next of kin or sponsor as well as who made the determination and what the recommendation was.

Upon receipt of the notification that the patient no longer requires his/her present level of care, the responsible social services district shall complete a notification of proposed transfer/discharge and fair hearing rights (a model letter is attached). Copies of this notification shall be sent to the recipient, his/her relative or representative, the facility administrator and the attending physician.

Medical Assistance payments to the facility shall be continued in all instances when the recommendation is for a higher level of care. If the patient chooses to remain at the lower level of care against the recommendation of the utilization review committee, his/her attending physician or facility medical director, he/she will be opting to remain at the less expensive level. There is, therefore, no fiscal incentive to discontinuing payment.

Medical Assistance payments to the facility shall be continued when the recommendation is for a lower level of care until the patient has an opportunity to request a fair hearing and until a fair hearing decision is reached if the patient requests a fair hearing.

Payments must also continue during the period in which the facility is arranging alternate care placement in accordance with departmental regulation 18 NYCRR 505.20.

If you have any questions concerning these interim procedures, please contact me at (518) 474-9176. Thank you for your cooperation.

Sincerely,

DEC 2 2 1980

Richard Ruid
Senior Social Services
Program Specialist

Enclosure
cc: L. Nestle
A. Maddaloni
A. Roberts
L. Glasser
M. Abel
RR:paz

December 18, 1980

Ulster County Department
of Social Services
Nursing Home Unit
Ulster County Office Building
244 Fair Street
Kingston, NY 12401

Dear Nursing Home Liason:

We have been informed by the Office of Health Systems Management White Plains regional office that a residential health care facility patient who is an Ulster County Medical Assistance recipient has been recommended for transfer by her attending physician. We are now required to notify this patient of her right to a fair hearing. This letter presents the recommended procedure for fair hearing notification in these instances. The recipient is Gilberta Kaman, MA 36074 at the Ulster County Infirmary.

The additional fair hearing notification requirement is as a result of the latest court order in the Yaretsky v. Blum case. Medical Assistance recipients in RHCFs who are determined to require a higher or lower level of nursing care regardless of whether the proposed transfer is based on a decision by the utilization review committee, attending physician, or facility medical director are now entitled to a fair hearing. It should be noted that while we are under a court order to implement this procedure, the order is being appealed and finalized procedures in the form of an Administrative Directive will not be issued until the Court of Appeals makes its final determination. While these fair hearings will normally deal only with medicaid level of care determinations which are ultimately the responsibility of the Office of Health Systems Management and not the local Department of Social Services, we are under an obligation to offer the recipient a fair hearing.

Facilities will continue to follow the procedures that are specified in Health Facilities Memorandum 80-27 (4/15/80), and 80-ADM-12 (2/29/80) if the utilization review committee determines (based upon a continued stay review) that a patient/resident requires transfer to a lower level of care. However, all other cases involving proposed transfer to a higher or lower level of care fall under the procedures contained in this letter. This latest court order does not effect direct transfers from residential health care facilities to hospitals.

When the utilization review committee recommends transfer to a higher level of care or when the attending physician or facility medical director recommend transfer to a higher or lower level of care, the residential health care facility must notify the patient/resident, attending physician, next of kin or sponsor and the responsible local department of social services. This notification will contain the name and address of the attending physician, next of kin or sponsor as well as who made the determination and what the recommendation was.

Upon receipt of the notification that the patient no longer requires his/her present level of care, the responsible social services district shall complete a notification of proposed transfer/discharge and fair hearing rights (a model letter is attached). Copies of this notification shall be sent to the recipient, his/her relative or representative, the facility administrator and the attending physician.

Medical Assistance payments to the facility shall be continued in all instances when the recommendation is for a higher level of care. If the patient chooses to remain at the lower level of care against the recommendation of the utilization review committee, his/her attending physician or facility medical director, he/she will be opting to remain at the less expensive level. There is, therefore, no fiscal incentive to discontinuing payment.

Medical Assistance payments to the facility shall be continued when the recommendation is for a lower level of care until the patient has an opportunity to request a fair hearing and until a fair hearing decision is reached if the patient requests a fair hearing.

Payments must also continue during the period in which the facility is arranging alternate care placement in accordance with departmental regulation 18 NYCRR 505.20.

If you have any questions concerning these interim procedures, please contact me at (518) 474-9176. Thank you for your cooperation.

Sincerely,

Richard Ruid
Senior Social Services
Program Specialist

Enclosure 1
cc: L. Nestle
A. Maddaloni
A. Roberts
L. Glasser
M. Abel

STATE OF NEW YORK
DEPARTMENT OF HEALTH OFFICE OF HEALTH SYSTEMS MANAGEMENT

TOWER BUILDING ○ THE GOVERNOR NELSON A. ROCKEFELLER EMPIRE STATE PLAZA ALBANY, N.Y. 12237

DAVID AXELROD, M.D.
Commissioner

May 4 10 44 AM '81

April 27, 1981

Paul K. Jensen
Assistant Administrator
Eger Nursing Home
140 Meisner Avenue
Staten Island, New York 10306

Dear Mr. Jensen:

I am in receipt of you April 16, 1981, letter to me concerning proposed discharge of patients by attending physicians.

Your understanding of my previous statements were correct in that attending physician initiated discharges are not constrained by the first partial final judgment in Yaretsky vs. Blum. Where a non-UR related discharge is proposed, the patient does have the right to a fair hearing, but the facility is not required to follow the procedures outlined in Health Facilities Memorandum 80-27. A New York State Department of Health memorandum will be released to address these differences.

In response to your two specific questions, I offer the following:

1. A physician does have the authority to discharge a patient from any health care facility, however, the federal court has ruled that a Medicaid patient may challenge that decision by requesting a fair hearing.

2. A physician's order to discharge a patient does not require notification to the UR Committee unless the patient's continued stay review date corresponds with the physician's order. In this case, all pertinent medical information, including the physician's discharge order, must be available to the UR Committee and any subsequent decision would require compliance with Health Facilities Memorandum 80-27. If the patient is not scheduled for

a continued stay review, and the physician orders discharge, the patient may be discharged unless a fair hearing is requested.

I am sorry if you have had difficulty with the fair hearing process and by copy of this letter I am notifying Mr. Phil Nostramo, New York State Department of Social Services, of this decision for his review.

If you have any further questions or concerns relative to this matter, please feel free to contact me.

Sincerely,

Anthony J. Maddaloni
Health Program Administrator
Bureau of Long Term Care Services

No. 80-1952
80-6890

RECEIVED
JUN 2 0 1981
OFFICE OF THE CLERK
SUPREME COURT, U.S.

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, as Commissioner of the New York State Department of Health,

Petitioners,

-against-

WILLIAM YARETSKY, RALPH CUEVAS and THE GRAY PANTHERS, NEW YORK CHAPTER

Respondents-Cross-Petitioners,

-and-

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents-Cross-Petitioners.

MOTION FOR LEAVE TO FILE PLAINTIFFS' BRIEF IN OPPOSITION TO DEFENDANTS' PETITION FOR CERTIORARI AND PLAINTIFFS' CROSS-PETITION FOR CERTIORARI AND TO PROCEED IN THIS CASE IN FORMA PAUPERIS

Pursuant to Rule 46 of the Rules of this Court, motion is hereby made that plaintiffs be allowed to file their brief in opposition to defendants' petition for certiorari and their cross-petition for certiorari in unprinted form and to proceed in this case in forma pauperis for the reasons stated in the attached affidavits of plaintiffs. Plaintiffs were permitted to proceed in forma pauperis in

both the District Court and the Court of Appeals in this case.

KALMAN FINKEL
Attorney-in-Charge
The Legal Aid Society
Civil Division

JOHN E. KIRKLIN
Director of Litigation
Civil Appeals & Law Reform Unit
The Legal Aid Society
11 Park Place - 8th Floor
New York, New York 10007
(212) 227-2755

DAVID GOLDFARB
The Legal Aid Society
953 Southern Blvd.
Bronx, New York 10459

CHARLES ROBERT
91 North Franklin Street
Room 205
Hempstead, New York 11550

Attorneys for Plaintiffs-Respondents-
Cross-Petitioners

No. 80-

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, as Commissioner of the New York State Department of Health,

Petitioners,

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents-Cross-Petitioners,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents-Cross-Petitioners.

AFFIDAVIT IN SUPPORT OF MOTION TO FILE BRIEF OPPOSING PETITION FOR WRIT OF CERTIORARI AND PLAINTIFFS' CROSS-PETITION FOR A WRIT OF CERTIORARI AND TO PROCEED IN THIS COURT IN FORMA PAUPERIS

I, MARY FOLEY, being first duly sworn, depose and say that I am a respondent in the above-entitled case; that in support of my motion to file a brief opposing the petition for a writ of certiorari and plaintiffs' cross-petition for a writ of certiorari and to proceed in this court in forma pauperis without being required to prepay fees, costs or give security therefor, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; and that I believe I am entitled to redress.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the cost of responding to the petition and filing the cross-petition are true.

1. Are your presently employed?

a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.

NO

b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received.

1970 . About $400 per month

2. Have you received within the past twelve months any income from a business, profession or other form of self-employment, or in the form of rent payments, interest, dividends, or other source?

No.

a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months.

3. Do you own any cash or checking or savings account?

None to my knowledge

a. If the answer is yes, state the total value of the items owned.

4. Do you own any real estate, stocks, bonds, notes, automobiles, or other valuable property (excluding ordinary household furnishings and clothing)?

No.

a. If the answer is yes, describe the property and state its approximate value.

5. List the persons who are dependent upon you for support and state your relationship to those persons.

None

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

MARY FOLEY

SUBSCRIBED AND SWORN TO before me this 12th day of June, 19 81.

MARTIN C. PRICE
Notary Public, State of New York
No. 31 4525922
Qualified in Kings County
Commission Expires March 30, 19 82

No. 80-

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, as Commissioner of the New York State Department of Health,

Petitioners,

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

AFFIDAVIT IN SUPPORT OF MOTION TO FILE BRIEF OPPOSING PETITION FOR WRIT OF CERTIORARI AND PLAINTIFFS' CROSS-PETITION FOR A WRIT OF CERTIORARI AND TO PROCEED IN THIS COURT IN FORMA PAUPERIS

I, ROSE SHULMAN, being first duly sworn, depose and say that I am a respondent in the above-entitled case; that in support of my motion to file a brief opposing the petition for a writ of certiorari and plaintiffs' cross-petition for a writ of certiorari and to proceed in this court in forma pauperis without being required to prepay fees, costs or give security therefor, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; and that I believe I am entitled to redress.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the cost of responding to the petition and filing the cross-petition are true.

1. Are your presently employed?

NO

a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.

b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received.

Was never employed outside the home

2. Have you received within the past twelve months any income from a business, profession or other form of self-employment, or in the form of rent payments, interest, dividends, or other source?

NO.

a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months.

3. Do you own any cash or checking or savings account?

No

a. If the answer is yes, state the total value of the items owned.

4. Do you own any real estate, stocks, bonds, notes, automobiles, or other valuable property (excluding ordinary household furnishings and clothing)?

No

a. If the answer is yes, describe the property and state its approximate value.

5. List the persons who are dependent upon you for support and state your relationship to those persons.

None

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

Rose Shulman

ROSE SHULMAN

SUBSCRIBED AND SWORN TO before me this 12th day of June, 19 81.

Martin C. Price

MARTIN C. PRICE
Notary Public, State of New York
No. 31-4525922
Qualified in Kings County
Commission Expires March 30, 19 82

No. 80-

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, as Commissioner of the New York State Department of Health,

Petitioners,

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

AFFIDAVIT IN SUPPORT OF MOTION TO FILE BRIEF OPPOSING PETITION FOR WRIT OF CERTIORARI AND PLAINTIFFS' CROSS-PETITION FOR A WRIT OF CERTIORARI AND TO PROCEED IN THIS COURT IN FORMA PAUPERIS

I, RAE WOLPER, being first duly sworn, depose and say that I am a respondent in the above-entitled case; that in support of my motion to file a brief opposing the petition for a writ of certiorari and plaintiffs' cross-petition for a writ of certiorari and to proceed in this court in forma pauperis without being required to prepay fees, costs or give security therefor, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; and that I believe I am entitled to redress.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the cost of responding to the petition and filing the cross-petition are true.

1. Are your presently employed?

No

a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.

b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received.

1956 $100 per month

2. Have you received within the past twelve months any income from a business, profession or other form of self-employment, or in the form of rent payments, interest, dividends, or other source?

No

a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months.

3. Do you own any cash or checking or savings account?

No

a. If the answer is yes, state the total value of the items owned.

4. Do you own any real estate, stocks, bonds, notes, automobiles, or other valuable property (excluding ordinary household furnishings and clothing)?

NO.

a. If the answer is yes, describe the property and state its approximate value.

5. List the persons who are dependent upon you for support and state your relationship to those persons.

NONE

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

Rae Wolper

RAE WOLPER

SUBSCRIBED AND SWORN TO before me this 12th day of June, 19 81.

Martin C. Price

MARTIN C. PRICE
Notary Public, State of N
No. 31-4525922
Qualified in Kings Co
Commission Expires March 30, 1982

No. 80-

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, as Commissioner of the New York State Department of Health,

Petitioners,

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

AFFIDAVIT IN SUPPORT OF MOTION TO FILE BRIEF OPPOSING PETITION FOR WRIT OF CERTIORARI AND PLAINTIFFS' CROSS-PETITION FOR A WRIT OF CERTIORARI AND TO PROCEED IN THIS COURT IN FORMA PAUPERIS

I, PAULINE ASHKENAZY, being first duly sworn, depose and say that I am a respondent in the above-entitled case; that in support of my motion to file a brief opposing the petition for a writ of certiorari and plaintiffs' cross-petition for a writ of certiorari and to proceed in this court in forma pauperis without being required to prepay fees, costs or give security therefor, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; and that I believe I am entitled to redress.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the cost of responding to the petition and filing the cross-petition are true.

1. Are your presently employed?

No

a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.

b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received. 1970 $ [illegible]

2. Have you received within the past twelve months any income from a business, profession or other form of self-employment, or in the form of rent payments, interest, dividends, or other source?

No

a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months.

3. Do you own any cash or checking or savings account?

No

a. If the answer is yes, state the total value of the items owned.

4. Do you own any real estate, stocks, bonds, notes, automobiles, or other valuable property (excluding ordinary household furnishings and clothing)?

No.

a. If the answer is yes, describe the property and state its approximate value.

5. List the persons who are dependent upon you for support and state your relationship to those persons.

None

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

Pauline Ashkenazy

PAULINE ASHKENAZY

SUBSCRIBED AND SWORN TO before me this 12th day of June, 19 81.

Martin C. Price

MARTIN C. PRICE
Notary Public, State of New York
No. 31-4525922
Qualified in Kings County
Commission Expires March 30, 19 82

No. 80-

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, as Commissioner of the New York State Department of Health,

Petitioners,

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE POSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

AFFIDAVIT IN SUPPORT OF MOTION TO FILE BRIEF OPPOSING PETITION FOR WRIT OF CERTIORARI AND PLAINTIFFS' CROSS-PETITION FOR A WRIT OF CERTIORARI AND TO PROCEED IN THIS COURT IN FORMA PAUPERIS

I, JAMES LUNDY, being first duly sworn, depose and say that I am a respondent in the above-entitled case; that in support of my motion to file a brief opposing the petition for a writ of certiorari and plaintiffs' cross-petition for a writ of certiorari and to proceed in this court in forma pauperis without being required to prepay fees, costs or give security therefor, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; and that I believe I am entitled to redress.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the cost of responding to the petition and filing the cross-petition are true.

1. Are your presently employed?

NO.

a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.

b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received.

1961. About $450 per month

2. Have you received within the past twelve months any income from a business, profession or other form of self-employment, or in the form of rent payments, interest, dividends, or other source?

No.

a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months.

3. Do you own any cash or checking or savings account?

No.

a. If the answer is yes, state the total value of the items owned.

4. Do you own any real estate, stocks, bonds, notes, automobiles, or other valuable property (excluding ordinary household furnishings and clothing)?

No.

a. If the answer is yes, describe the property and state its approximate value.

5. List the persons who are dependent upon you for support and state your relationship to those persons.

NONE

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

James Lundy

JAMES LUNDY

SUBSCRIBED AND SWORN TO before me this 10th day of June, 1981.

Martin O. Price

MARTIN O. PRICE
Notary Public, State of New York
No. 31-4525922
Qualified in Kings County
Commission Expires March 30, 1982

No. 80-

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1980

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, as Commissioner of the New York State Department of Health,

Petitioners,

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

AFFIDAVIT IN SUPPORT OF MOTION TO FILE BRIEF OPPOSING PETITION FOR WRIT OF CERTIORARI AND PLAINTIFFS' CROSS-PETITION FOR A WRIT OF CERTIORARI AND TO PROCEED IN THIS COURT IN FORMA PAUPERIS

I, PHILOMENA LATONA LUNDY, being first duly sworn, depose and say that I am a respondent in the above-entitled case; that in support of my motion to file a brief opposing the petition for a writ of certiorari and plaintiffs' cross-petition for a writ of certiorari and to proceed in this court in forma pauperis without being required to prepay fees, costs or give security therefor, I state that because of my poverty I am unable to pay the costs of said proceeding or to give security therefor; and that I believe I am entitled to redress.

I further swear that the responses which I have made to the questions and instructions below relating to my ability to pay the cost of responding to the petition and filing the cross-petition are true.

1. Are your presently employed?

NO.

a. If the answer is yes, state the amount of your salary or wages per month and give the name and address of your employer.

b. If the answer is no, state the date of your last employment and the amount of the salary and wages per month which you received.

1951 Does not remember

2. Have you received within the past twelve months any income from a business, profession or other form of self-employment, or in the form of rent payments, interest, dividends, or other source?

No.

a. If the answer is yes, describe each source of income, and state the amount received from each during the past twelve months.

3. Do you own any cash or checking or savings account?

No.

a. If the answer is yes, state the total value of the items owned.

4. Do you own any real estate, stocks, bonds, notes, automobiles, or other valuable property (excluding ordinary household furnishings and clothing)?

NO.

a. If the answer is yes, describe the property and state its approximate value.

5. List the persons who are dependent upon you for support and state your relationship to those persons.

NONE

I understand that a false statement or answer to any questions in this affidavit will subject me to penalties for perjury.

Philomena Latona Lundy
PHILOMENA LATONA LUNDY

SUBSCRIBED AND SWORN TO before me this 12th day of June, 19 81.

Martin L. Price
MARTIN C. PRICE
Notary Public, State of New
No. 31-4525922
Qualified in Kings County
Commission Expires March 30, 1982

Office - Supreme Court, U.S.
FILED
DEC 5 1981
STEVAS.

No. 80-1952

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, M.D., as Commissioner of the New York State Department of Health,

Petitioners

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS

ROBERT ABRAMS
Attorney General of the
State of New York
Attorney for Petitioners
Two World Trade Center
New York, New York 10047
(212) 488-2462

SHIRLEY ADELSON SIEGEL
Solicitor General
JUDITH A. GORDON
ANDREA G. IASON
Assistant Attorneys General
of Counsel

Questions Presented

1. Should the Court of Appeals have determined the due process rights of Medicaid patients in nursing homes who are transferred from one level of care to another by their private physicians or nursing homes or from a lower to a higher level of care by federally-mandated Utilization Review Committees when no named respondent, intervenor or representative class member alleged that he had been, or imminently would be, subject to such a transfer?

2. Is the transfer of a patient from one level of care to another, by a private physician or other private party, affected by state action solely because the patient is Medicaid-funded and one result of the transfer is a change in the amount of benefits paid on his behalf?*

---

* The petition for a writ of certiorari presented four questions for review. Petition p. i. The writ was granted on questions 1 and 2. October 5, 1981 Order in Docket Number 80-1952.

Parties in the Court Below

The caption of this proceeding lists the parties in the court below except that David Axelrod, M.D., as Commissioner of the New York State Department of Health, has been added as a petitioner and Robert Whalen, M.D., a defendant-appellant below individually and as Commissioner of the New York State Department of Health, has been dropped. Dr. Axelrod succeeded Dr. Whalen as Commissioner of the New York State Department of Health on January 2, 1979 and is substituted for him under Rule 25(d)(1) of the Federal Rules of Civil Procedure. No relief was awarded against Dr. Whalen individually.

Reference to petitioner Barbara Blum individually has been deleted from the caption of this proceeding. Mrs. Blum succeeded Carmen Shang as Commissioner of the New York State Department of Social Services on November 7, 1977 and was substituted for him under Rule 25(d)(1) of the Federal Rules of Civil Procedure. No relief was awarded against Mrs. Blum while she was named in that capacity.

PAGE

Questions Presented i

Parties in the Court Below ii

Opinions and Judgments Below 1

Jurisdiction 3

Statement of the Case 3

Summary of Argument 23

POINT I—The district court did not have jurisdiction to determine whether state action was involved in private physician or nursing home transfers of Medicaid patients to different levels of care or in Utilization Review Committee transfers of these patients to higher levels of care. No respondent, intervenor or class representative complained that he was either transferred or threatened with transfer in this matter 25

POINT II—Decisions by private physicians and nursing homes to transfer Medicaid patients to different levels of care and by Utilization Review Committees to transfer these patients to higher levels of care do not become decisions of the State because the patients' benefits are increased or decreased, when warranted, to reflect differences in the cost of care 31

Conclusion 39

Exhibit 1a

Cases

PAGE

Bailey v. *Patterson*, 369 U.S. 31 (1962) 29

Barrett v. *United Hospital*, 376 F. Supp. 791 (S.D.N.Y. 1974), *aff'd mem.* 506 F.2d 1395 (2d Cir. 1974) 36

Burton v. *Wilmington Park Authority*, 365 U.S. 715 (1961) 32

Feld v. *Berger*, 424 F. Supp. 1356 (1976) 6, 11

Flagg Brothers, Inc. v. *Brooks*, 436 U.S. 149 (1978) 31, 33, 35

Flast v. *Cohen*, 392 U.S. 83 (1968) 25

Fried v. *Straussman*, 41 N.Y. 2d 376 (1977) 36

Fuzie v. *Manor Care, Inc.*, 461 F. Supp. 689 (N.D. Ohio 1977) 36

Gladstone Realtors v. *Village of Bellwood*, 441 U.S. 91 (1979) 23, 25, 27

Grey Panthers v. *Schweiker*, —— U.S. ——, 101 S. Ct. 2633 (1981) 30

Grossner v. *Trustees of Columbia University*, 287 F. Supp. 535 (S.D.N.Y. 1968) 32

H. L. v. *Matheson*, —— U.S. ——, 101 S.Ct. 1164 (1981) 25

Indiana Employment Division v. *Burney*, 409 U.S. 540 (1973) 29

Jackson v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974) .....*passim*

O'Bannon v. *Town Court Nursing Center*, 447 U.S. 773 (1980) 22

PAGE

O'Shea v. *Littleton*, 414 U.S. 448 (1974) 23, 25, 29

Planned Parenthood of Missouri v. *Danforth*, 428 U.S. 52 (1976) 34

Powe v. *Miles*, 407 F.2d 73 (2d Cir. 1968) 32

Roe v. *Wade*, 410 U.S. 113 (1973) 25

Rush v. *Parham*, 440 F. Supp. 383 (N.D. Ga. 1977) .. 37

Schlein v. *Milford Hospital, Inc.*, 516 F.2d 427 (2d Cir. 1977) 36

Sigety v. *Ingraham*, 29 N.Y.2d 110 (1971) 4, 38

Szekely v. *Florida Medical Association*, 517 F.2d 345 (5th Cir. 1975) 37

Sierra Club v. *Morton*, 405 U.S. 727 (1972) 30

Wagner v. *Sheltz*, 471 F. Supp. 903 (D. Conn. 1979) .. 36

Warth v. *Seldin*, 422 U.S. 490 (1975) 25, 30

CONSTITUTION

U.S. Const. art. III, sec. 2 25

FEDERAL STATUTES

28 U.S.C. § 1254 3

§ 1331 10

§ 1343 10

§ 2101 3

42 U.S.C. § 1395x 4

§ 1396 et seq. 8

§ 1396a 4, 5, 22, 36

PAGE

§ 1396b 5, 10

§ 1396d 4

Pub. L. 92-603, 86 Stat. 1379 5

FEDERAL REGULATIONS

42 C.F.R. § 250.19 12

§ 405.1121 10

§ 442.202 10

§ 442.253 10

§ 442.311 10

§ 450.19 12

§ 456.406 5

§ 456.333 5

§ 456.334 5

§ 456.336 5

§ 456.337 ..... 5, 12

§ 456.338 12

§ 456.437 12

§ 456.438 12

§ 456 Subparts A, B, E, F 9

45 C.F.R. § 205.10 ..... 9, 11, 12, 13, 22

§ 205.100 ..... 12, 13

§ 249.10 10

§ 249.12 10

§ 250.18 9

§ 250.19 9

Federal Rules

	PAGE
F.R.C.P. Rule 25	ii
Supreme Court Rules	
Rule 20	3
23	2
30	2

State Statutes

Public Health Law § 2801	4
§ 2807	4, 38
Social Services Law § 366	4

State Regulations

10 N.Y.C.R.R. § 360.29	4
§ 360.33	6
Part 414-416	4
Part 420	4
Part 421	4
Subpart 86-2	4, 38
18 N.Y.C.R.R. § 358.8	11
§ 358.9	11
§ 358.12	11
§ 485.2	7
§ 486	7
§ 487	7

MISCELLANEOUS

PAGE

L. Stern and E. Gressman, Supreme Court Practice, 885 (5th ed. 1978) 25, 26

39 (231) Fed. Reg. 41604 (November 29, 1974) 5

39 (231) Fed. Reg. 41610 (November 29, 1974) 5

In the

Supreme Court of the United States

OCTOBER TERM, 1981

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, M.D., as Commissioner of the New York State Department of Health,

Petitioners,

against

WILLIAM YARETSKY, RALPH CUEVAS and THE GRAY PANTHERS, New York Chapter,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SECOND CIRCUIT

BRIEF FOR PETITIONERS

Opinions and Judgments Below

The order of the Court of Appeals denying petitioners' request for rehearing of the opinion and judgment on review is not reported. The order is reproduced at A. 260-61.*

---

* References preceded by "A." are to the joint appendix filed in this proceeding.

The opinion and judgment of the Court of Appeals on review is reported at 629 F.2d 817. It is reproduced at A. 245-59.

The district court memorandum opinion endorsed and partial final judgment that was affirmed in part, vacated in part and modified by the opinion and judgment on review are not reported. The memorandum opinion endorsed is reproduced at A. 240, and the partial final judgment is reproduced at A. 241-43.

Other reported opinions and judgments in the record on appeal are at 592 F.2d 65 (reproduced at A. 122-33) and 456 F. Supp. 653 (record on appeal document number [hereafter "R.A. Doc. No."] 59*).

---

* Documents not reproduced in the joint appendix are cited to the record on appeal. See Rules 23(2) and 30(2) of the Supreme Court Rules. The record on appeal is designated by Court of Appeals docket number 80-7197. It includes the records on appeal in earlier and later Second Circuit appeals in this case. The earlier appeal, No. 78-7077, affirmed a preliminary injunction (A. 99-103) insofar as appealed. 592 F.2d 65, A. 122-33. The later appeal, No. 80-7559 (with cross appeal No. 80-7625) from an order dated June 9, 1980 (R.A. Doc. No. 114), was withdrawn. The Clerk of the Court of Appeals has marked the 80-7559 record on appeal as the second supplemental record on appeal in 80-7197 although it was not docketed as part of the 80-7197 record while that appeal was pending. See Court of Appeals Docket Entries from March 12, 1980 (receipt of notice of appeal in 80-7197) through August 25, 1980 (Court of Appeals judgment in 80-7197 filed). A. 17. With the exception of respondents' motion for stay of the partial final judgment on appeal in 80-7197 (R.A. Doc. Nos. 106, 107) and the district court opinion (R.A. Doc. No. 115 pp. 13-14) and order (R.A. Doc. No. 114 ¶ 6) denying that motion, the 80-7559 record does not contain any proceedings on review.

The document numbers of all the substantive district court proceedings in the 80-7197 record on appeal, as they should appear in the Clerk of the Court of Appeals transmittal to this Court, are shown in the second column of the District Court Docket Entries. A. 1-16. Proceedings in No. 78-7077 and No. 80-7559 are so identified in the Docket Entries (*Ibid.*) and in this brief when appropriate to enhance clarity.

Other unreported district court opinions and memoranda in the record on appeal are dated January 10, 1978 (reproduced at A. 104-20) and June 9, 1980 (R.A. Doc. No. 115 in 80-7559).

Numerous unreported district court final orders and judgments are in the record on appeal. Substantive final orders and judgments are dated November 30, 1977 (reproduced at A. 40-42), December 13, 1977 (reproduced at A. 43-46), January 5, 1978 (reproduced at A. 99-103), January 10, 1978 (R.A. Doc. No. 25), February 17, 1978 (reproduced at A. 121), July 31, 1978 (R.A. Doc. No. 65), October 3, 1979 (R.A. Doc. No. 85), October 17, 1979 (reproduced at A. 227-39), May 7, 1980 (R.A. Doc. No. 113 in No. 80-7559), June 9, 1980 (R.A. Doc. No. 114 in No. 80-7559) and June 13, 1980 (R.A. Doc. No. 116 in No. 80-7559).

Jurisdiction

Jurisdiction is conferred on this Court by 28 USC § 1254(1).

The order of the Court of Appeals denying petitioners' request for rehearing of the opinion and judgment on review was filed on February 18, 1981. A. 260. The opinion and judgment of the Court of Appeals on review was filed on August 25, 1980. A. 17 (docket entry for 8/25/80), A. 245. The petition for a writ of certiorari, Docket Number 80-1952, was filed on May 19, 1981. See 28 USC § 2101(c); Rule 20(2), (4) of the Supreme Court Rules.

Statement of the Case

Respondents Yaretsky, Cuevas and the Gray Panthers, New York Chapter, commenced this action against the Commissioner of the New York State Department of Social Services on July 28, 1976 in the United States Dis-

trict Court for the Southern District of New York. District Court Docket Entries for 7/28/76 and 11/4/76, A. 1; R.A. Doc. Nos. 1, 3.* According to the First Amended Complaint, Yaretsky and Cuevas were patients in the American Nursing Home in New York City, and the cost of their care was paid by medical assistance or "Medicaid." A. 20-21 ¶¶ 3, 4; A. 25 ¶ 20.** In December 1975, American's Utilization Review Committee ("URC") decided that neither respondent needed the skilled nursing ("SNF") care American provided and that each should be transferred to a lower level of care in a health related

---

* The Commissioner of the New York State Department of Health was added as a defendant in the First Amended Complaint, dated February 9, 1977. A. 34.

** Medical assistance is an example of "cooperative federalisim" which permits participating states, like New York, to obtain federal aid ("FFP") to assist them in meeting the cost of medical care for the needy. States must operate their programs under approved state plans and comply with all federal requirements. 42 U.S.C. § 1396a. Under these requirements, individuals demonstrate their eligibility for assistance in terms of income and resources. 42 U.S.C. § 1396a(a)(10); New York Social Services Law ("SSL") § 366 (conforming state requirement). They can then obtain covered services, which include medically necessary long term care in skilled nursing facilities ("SNFs") and intermediate care facilities, denominated health related facilities ("HRFs") in New York, from any qualified providers they choose. 42 U.S.C. §§ 1396a(a)(23), 1396d(a)(4)(A),(c), (f); 10 New York Code, Rules and Regulations ("N.Y.C.R.R.") § 360.29. See 42 U.S.C. §§ 1395x(j), 1396a(a)(28), 1396d(i) (qualifications for SNF providers); 1396d(c) (qualifications for HRF providers); and New York Public Health Law ("PHL") §§ 2801(1)-(3), 2801-a; 10 N.Y.C.R.R. Parts 414-416, 420, 421 (conforming state requirements). Providers are, in turn, paid directly by state Medicaid authorities for the reasonable cost of care under that established reimbursement rates. PHL 2807(3); 10 N.Y.C.R.R. Subpart 86-2; *Sigety* v. *Ingraham*, 29 N.Y. 2d 110 (1971). HRFs provide less intensive care than SNFs (10 N.Y.C.R.R. §§ 416.1, 416.2, 421.2), and they are generally lower in cost. A. 169 ¶ I (12); A. 247.

facility, or "HRF." A. 25-26 ¶¶ 20, 21.* New York City social services officials, then responsible for administering certain long term care aspects of Medicaid, prepared to conform with the URC decisions by reducing the nursing home benefits paid on the respondents' behalf to the amount appropriate for the HRF provider or by discontinuing those benefits if American and the respondents did not follow the URC decisions. A. 25-26 ¶ 21.** State

* Utilization control, or review, is a federally mandated program which assists in the delivery of medical services to the individuals who need them in a cost-efficient manner. A requirement for effective utilization review and related FFP sanctions was added to the Medicaid program in 1972 by Pub. L. 92-603, 86 Stat. 1379. See 42 U.S.C. § 1396b(g)(1),(i)(4) and related amendments to § 1396a(a)(28) and (a)(30). Federal implementing regulations were not promulgated until November 29, 1974. 39 (231) Fed. Reg 41604-41608 (hospitals); 4160-41618 (SNFs and ICFs/HRFs). They are now codified 42 C.F.R. Part 456.

Utilization review is "peer review" of medical professionals by medical professionals. Every facility has its own URC which is appointed by the facility's management. SNF URCs must consist of at least two physicians, neither of which may be responsible for the care of the patient under review. HRF URCs must consist of at least one physician who may not be responsible for the care of the patient under review. 42 C.F.R. § 456.406. URCs periodically review continued patient stays to determine if the level of care being provided is appropriate. Each SNF patient must be reviewed every 90 days after an initial stay of 30 or 90 days, depending on the manner of admission (42 C.F.R. §§ 456.333, 456.334), and each HRF patient, every six months. 42 C.F.R. § 456.434. The URC must inform the patient under review and his attending physician, among others, if it decides to transfer the patient to a different level of care, and it must afford the attending physician an opportunity for comment. 42 C.F.R. §§ 456.336(f), 456.337, 456.436(f), 456.437. If the patient's attending physician disapproves of the transfer, two URC physicians must concur in it for it to become effective. 42 C.F.R. §§ 456.336(h), 456.436(h). Medicaid pays the providers the cost of URC services attributable to Medicaid patients within the limits of the reimbursement rates the state has established.

** New York State took over New York City's Medicaid responsibilities for nursing home care on April 15, 1977 (R.A. Doc. No. 16 [Williams affidavit], and the City defendant, joined early in the action (A. ¶ 12) was dismissed for that reason. A. 100 ¶ 1; A. 119-20. Prior to the state takeover, City Medicaid authorities reviewed URC continued stay decisions transferring

(footnote continued on following page)

social services officials affirmed the potential discontinuance of nursing home benefits after administrative fair hearings were afforded the two respondents. A. 26 ¶¶ 23, 24.*

According to the same complaint, the Gray Panthers, New York Chapter, was an association of 5,000 members, including Medicaid patients in nursing homes. A. 21 ¶ 5.

(footnote continued from preceding page)

patients to lower levels of care and approved or disapproved them. R.A. Doc. No. 16 (Baldwin affidavit ¶¶ 6-10). The state abandoned this practice and does not approve (other than by reason of the rulings below) or disapprove URC continued stay decisions. A. 148 (Maddaloni deposition).

* State Medicaid authorities initially opposed fair hearings following URC transfers to lower levels of care and questioned HEW (now HHS) on the point in an exchange of letters and telegrams which took place between March and July of 1976. R.A. Doc. No. 20 (Exhibits B-F to Steibel affidavit). In substance, the state argued that the URC regulations did not provide for another tier of review beyond the two URC physicians required to oppose an attending physician (discussion, p. 5 footnote); that both federal and state fair hearing requirements on reductions or terminations of assistance referred to 'agency action' as the cause for the reduction or termination of assistance and the social services agency, not a URC, was the agency contemplated; that the fair hearings, intended to review questions of individual eligibility based on income and resources, were not appropriate vehicles for reviewing the appropriateness of medical treatment; and that the provision of a fair hearing, particularly if current benefit levels were to continue until it was decided, opposed the URC purpose of timely transfers of patients to the levels of care suited to their medical needs. HEW's final response states in part (R.A. Doc. No. 16 [Exhibit F to Steibel affidavit]): "While the application of the fair hearing regulations to State agency actions based on Utilization Review Committee determinations may not be the most reasoned approach to the questions raised by Utilization Review determinations, they [including aid continuing] are nonetheless applicable." The state Medicaid authorities then conformed their program requirements, first with respect to notice and fair hearing rights and then, after the disposition in *Feld* v. *Berger*, 424 F. Supp. 1356 (S.D.N.Y. 1976), with respect to the timeliness of notice and aid continuing. See 10 N.Y.C.R.R. § 360.33.

HEW's position that fair hearings are required following URC transfers that result in reduction or terminations of benefits is also set forth in "All State Letter No. 76-4," dated February 10, 1976, included as an Exhibit to this brief. As there stated (p.2), no fair hearing rights are available to a patient whose own physician transfers him with the same result.

The association alleged that its members had been, or would be, injured by transfers like those planned for Yaretsky and Cuevas and that its objectives, advocacy of its members' rights and quality health care for the elderly, had been, or wouldd be impaired. A. 21 ¶¶ 5-7. The only additional substantive reference to the Gray Panthers during the proceedings below is in petitioners' Answer to the First Amended Complaint which acknowledges the Yaretsky and Cuevas transfers (A. 36-37 ¶¶ *Eighth, Ninth*) and otherwise denies the material allegations (A.35-37), including the description of the Gray Panthers and its status as a proper party. A. 35 ¶ *Third;* A. 37 ¶ *Fourteenth.*

The ten intervenors-respondents joined the action between November 28 and December 13, 1977. R.A. Doc. No. 57 Item 2 (Foley); A. 41 ¶ 2 (Wolper, Schulman, Rossoff, Ashkenazy); A. 45 ¶ 1 (Birenzweig, Zahl, Kolman, J. Lundy, P. Lundy). According to their complaints, the URCs of the nursing homes in which Foley, Birenzweig, Zahl and Kolman were patients had decided that these intervenors did not need the SNF care the nursing homes provided and that they should be transferred to lower levels of care in HRFs. A. 49 ¶ 12, A. 50 ¶ 17 (Foley); A. 76 ¶ 12, A. 77 ¶ 18 A. 78 ¶ 22 (Birenzweig); A. 79-80 ¶ 28, A. 80 ¶ 33, A. 81 ¶ 37 (Zahl); A. 82-83 ¶ 44, A. 83 ¶ 49, A. 84 ¶ 53 (Kolman). The URCs of the nursing homes in which Wolper, Shulman, Rossoff, Ashkenazy, and the Lundys were patients had decided that these intervenors did not need the HRF care the nursing homes provided and that they should be transferred, or, more accurately, discharged, to adult homes. A. 58 ¶ 12, A. 58-59 ¶¶ 17, 21 (Wolper); A. 61 ¶ 30, A. 62 ¶ 35 (Shulman); A. 65 ¶ 46, A. 66 ¶¶ 52, 53 (Rossoff); A. 68 ¶ 64, A. 69 ¶¶ 70, 74 (Ashkenazy); A. 85-86 ¶ 60, A. 86 ¶ 65, A. 87 ¶ 69 (J. Lundy); A. 88 ¶ 75, A. 89 ¶ 80, A. 90 ¶ 84 (P. Lundy).* Each intervenor

* New York certifies voluntary and proprietary "adult homes" which provide care for individuals who "by reason of physical or other limitations . . . [are] unable to live independently," 18 N.Y.C.R.R. § 485.2. See also 18 N.Y.C.R.R. Part 486 (operating certificates); Part 487 (transfers). The care includes "personal-

(footnote continued on following page)

had been afforded a state fair hearing, and the determination to discontinue Medicaid nursing home benefits if the nursing home provider and intervenor did not follow the relevant URC decision had been affirmed. A. 51 ¶ 20, A. 52 ¶ 27 (Foley); A. 77-78 ¶ 21, A. 78-79 ¶ 24 (Birenzweig). A. 81 ¶ 36, A. 81-82 ¶ 40 (Zahl); A. 84-85 ¶¶ 52, 56 (Kolman); A. 59 ¶ 20, A. 60 ¶ 26 (Wolper); A. 63 ¶ 39, A. 64 ¶ 42 (Shulman); A. 66 ¶ 55, A. 67 ¶ 60 (Rossoff); A. 69 ¶ 73, A. 70 ¶ 78 (Ashkenazy); A. 86-87 ¶¶ 68, 71 (J. Lundy); A. 89-90 ¶¶ 83, 86 (P. Lundy).* A class was certified on December 13, 1977 when the last (Birenzweig) group of intervenors joined. A. 45 ¶¶ 1, 2.** No person, organization or 'class representative' other than the respondents and intervenors just described was before the court during any of the proceedings below.

The First Amended Complaint alleged that the planned URC transfers of Yaretsky and Cuevas from SNF to HRF care violated their rights under the Due Process Clause of the Fourteenth Amendment, Title XIX (Medical Assistance) of the Social Security Act, 42 USC § 1396 *et seq.* and related federal regulations. A. 19-20 ¶ 1. More specifi-

---

(footnote continued from preceding page)

care services, supervision of attendants and other . . . services as are necessary to assure health, safety and well-being." *Ibid.* However, it is not considered medical or nursing care. As a result, adult homes are not qualified Medicaid providers and tranfers to their facilities are discharges from a medically oriented system to a non-medically oriented one.

* The URC transfers of the respondents and the interveners to lower levels of care were not in fact accomplished. Yaretsky and Cuevas apparently were not transferred because of the pendency of the lawsuit. All the intervenors obtained temporary restraining orders (A. 41-42 ¶ 4 [Wolper group]; A. 45-46, ¶ 3 [Birenzweig group]; R.A. Doc. No. 57 item 2 [Foley]), and an injunction was entered thereafter A. 100-102 ¶ 2.

** The class was denied as all SNF and HRF patients in New York "who, following utilization review recommendations and/or fair hearings, are determined by defendants [petitioners] to be ineligible to receive the level of care at the facilities in which they reside and to be subject to [transfers to lower levels of care, or discharges, and to] reduction or termination of their Medicaid benefits." A. 45 ¶ 2. See also January 10, 1978 preliminary injunction opinion certifying a sub-class of these patients who were denied adequate notice of the reasons for their transfers and access to documents and evidence prior to their fair hearings. A. 118.

cally, respondents claimed that URC transfers to lower levels of care and the corresponding reductions in Medicaid benefits were arbitrary and incorrect evaluations of patient needs and were decided by improperly constituted URCs without adequate written criteria and without affording attending physicians an opportunity to comment. A. 26-29 ¶¶ 25-39; A. 29-30 ¶¶ 36-39. They claimed further that patients were denied adequate notice of URC decisions and the reasons supporting them and of their rights to and at fair hearings. A. 29-30 ¶¶ 37, 38; A. 31-32 ¶¶ 43-48. A claim of entitlement to the adoption and enforcement of a state policy requiring nursing homes to provide multiple levels of care, i.e. both SNF and HRF, in a single facility, allegedly eliminating the need for 'involuntary' patient transfers, was also pleaded. A. 30 ¶¶ 40-42.* Declaratory and injunctive relief and damages in the amount of one million dollars ($1,000,000.00) were sought. A. 32-33 ¶¶ 3-5. Jurisdiction was alleged under

---

* The following sections of Title XIX, 42 USC, were cited in support: §§ 1396a(a)(3) (fair hearings required for individuals whose Medicaid claims are denied or not determined promptly); 1396a(a)(17) (reasonable standards required to determine eligibility and amount of assistance); and 1396a(a)(19) (safeguards required to assure that eligibility is determined and care and services provided consistently with simplicity of administration and the best interests of the patients). A. 28-29 ¶ 35(c)-(e); A. 30 ¶¶ 39(b), 42; A. 32 ¶ 3(a). The following sections of C.F.R., Title 45, were cited in support: § 205.10(a) (circumstances requiring administrative hearings for categorical assistance recipients and procedural rights); § 250.18 (Medicaid state plans must include a utilization control program to safeguard against unnecessary care and services); and § 250.19(a)(3) and (4) (SNF and ICF [HRF] utilization review procedures, including the composition and duties of URCs). A. 28 ¶ 35(a), (b); A. 30 ¶ 39(a); A. 31 ¶ 48(a); A. 32-33 ¶ 3(a), (d). 45 C.F.R. §§ 250.18 and 250.19(a) (3) and (4) have been recodified in 42 C.F.R. Part 456 (1980). See Redesignation Table II p. 813 and Redesignation Table III pp. 822-28 in 42 C.F.R. Part 400 to End (1980). Requirements that Medicaid state plans include utilization control programs are at 42 C.F.R. part 456 Subparts A and B (1980). Requirements for SNF and HRF utilization control, including the composition and duties of URCs, are at 42 C.F.R. Part 456 Subpart F (SNFs) and Subpart E (HRFs).

28 U.S.C. §§ 1331 and 1343 (3), (4). A. 20 ¶ 2. The intervenor complaints advanced essentially the same claims and sought the same relief. The Wolper complaint and the Birenzweig complaint (for J. Lundy and P. Lundy only) expand, and complete, the factual basis for the action by relying on URC transfers, or discharges, from HRFs to adult homes. See discussion, p. 7.*

On January 5, 1978, the district court issued a preliminary injunction on respondents' claims about patient notice of URC transfers to lower levels of care, including discharges to adult homes, the reasons supporting those transfers and the opportunity to contest them at administrative fair hearings. The injunction restrained petitioners, *inter alia,* from reducing or terminating Medicaid nursing home benefits for any class member, based on a URC decision that he did not need the level of care he was receiving, without (a) timely written notice to the patient, provided by state or local social services or health officials, advising him of the reasons for the URC decision, the proposed action of the social services officials to reduce or terminate benefits with citations to supporting regulatory authorities, and the patient's right to an evidentiary fair hearing and continuing benefits until his claim was decided administratively, and (b) written notice to the patient advising him of his right to examine

---

* The following additional authorities are cited in support of the claims against URC discharges from HRFs to adult homes: 42 U.S.C. § 1396b(g)(1) (mandating decreases in FFP to states which do not have utilization control programs in effect); 45 C.F.R. §§ 249.10(a)(15) defining intermediate [HRF] care) and 249.12 (declaring patient rights not to be transferred or discharged from nursing homes except for medical reasons, the patients' welfare, the welfare of other patients or nonpayment). A. 72-73 ¶¶ 92, 95, 98, 101. Sections 249.10(a)(15) and 249.12 have been recodified in C.F.R., Title 42. See Redesignation Table II p. 813 and Redesignation Table III pp. 818-22 in 42 C.F.R. Part 400 to End (1980). Intermediate (HRF) care is defined at 42 C.F.R. 442.253 (1980); SNF patient rights are at §§ 405.1121(k), 442.202(c); and HRF patient rights, at § 442.311(c).

his case files and medical records before the fair hearing, including the material relied on by the URC and the material to be used against him at the hearing. A. 100-102 ¶ 2.*

Petitioners thereafter moved to alter or amend the injunction in two respects. R.A. Doc. Nos. 28, 29. They asked for (a) relief from the requirement that health or social services officials, rather than nursing homes or URCs, provide the mandated notices of reasons for URC decisions, corresponding reductions or terminations of benefits and fair hearing rights, and (b) permission to withhold medically contraindicated information from a patient during pre-hearing disclosure if the patient's physician decided that the patient should not be informed of his condition. *Ibid.***

---

* The January 10, 1978 opinion in support of the injunction recognizes that the respondents' claims (except for the description of the reasons for the URC decision and the reasons for reduction or termination of benefits to be detailed in the patient notice) had been resolved in favor of similarly situated nursing home patients in *Feld* v. *Berger*, 424 F. Supp. at 1360-63 (timely notice and aid continuing); *id.* 1363 (access to case files and medical records, including potentially harmful, or "medically contraindicated" information) and adopts that opinion in relevant part. A. 112-13. The holdings on the injunction in this case and in *Feld* rely exclusively on the interpretation of federal and state regulations. A. 112, citing 45 C.F.R. § 205.10(a)(4)(i)(B) and 18 N.Y.C.R.R. § 358.8(a)—detailed written description of reasons for agency action required; *Feld* v. *Berger*, *supra*, citing 45 C.F.R. §§ 205.10(a)(4)(i)(A), 205.10(a)(4)(ii)(D), 205.10(a)(6)(i)—timely notice and aid continuing, citing § 205.10(a)(13)(i) and 18 N.Y.C.R.R. §§ 358.9(d), 358.12—access to case files and medical records. See discussion, p. 5 footnote. The due process claims in both cases are mentioned and characterized as not insubstantial. A. 114 (January 10, 1978 opinion); *Feld*, *supra*, at 1360 n.12.

** Compliance with the requirement that health and social services officials provide notices of the reasons for URC decisions, corresponding reductions or terminations of benefits and fair hearing rights meant that patients would receive two notices about URC transfers to lower levels of care, one mandated by the injunction, and one mandated by federal regulations which obligated URCs

(footnote continued on following page)

The district court denied the relief (A. 121), and petitioners appealed from the injunction, raising the two issues presented on the motion to alter or amend. A. 123-24. The Court of Appeals affirmed the district court. A. 125 (January 16, 1979 Court of Appeals Opinion). On the first issue, the majority held that federal regulations require two notices, one from URCs and another from state or local agencies responsible for the Medicaid program. The URC is to inform the patient about its decision to reduce the level of care he is receiving, a matter consistent with the doctor-patient framework in which the URC operates. A. 126-27 (relying on the regulations cited at p. 11, second footnote). The state or local public agency is to inform the patient that his benefits will be correspondingly reduced or terminated and of his fair hearing rights. A. 125, 126, 127 (relying on 45 C.F.R. § 205.10[a][4][i]). According to the majority, the state or local agency cannot delegate its obligation to notify, to a nursing home or URC, because the applicable regulations preclude delegation to private parties. A. 126. The majority states (A. 126 n. 2): "It [45 C.F.R. § 205.10 (a)(4)(i)] does not permit notice [for which public agencies are responsible] to be given by a private party or 'the Utilization Review Committee' of a private party." And further (*id.* n. 3): "45 C.F.R. § 205.100(b)(i) permits delegation 'by [to] other state or local agencies' but in

---

(footnote continued from preceding page)

to provide notice of their adverse decisions, i.e. 42 C.F.R. §§ 456.337, 456.338 (SNFs) (42 C.F.R. § 450.19[a][3][ix][G], [F] at the time of the motion); 456.437, 456.438 (IRFs) (42 C.F.R. § 250.19[a][4][vii][F], [G] at the time of the motion). A 'dual notification system' in effect prior to the injunction had been abandoned as confusing to the patients and inefficient. R.A. Doc. No. 28 Davidoff affidavit ¶¶ 3-7; *Id.* Skerrett affidavit ¶¶ 4-6, 8. The 'single notification system' petitioners preferred, required the nursing homes or URCs to incorporate notices of reductions or terminations of benefits and fair hearing rights in every URC notice of an adverse decision. R.A. Doc. No. 28 Davidoff affidavit ¶ 6; *Id.* Skerrett affidavit ¶¶ 6, 8.

no case permits delegation to a private party such as a health care facility or its 'Utilization Review Committee.' "* On the second issue, the full court held that medically contraindicated information was not exempt from the disclosure requirement of 45 C.F.R. § 205.10(a)(13)(i) and that its usefulness to a patient opposing a URC transfer to a lower level of care outweighed the risk that the patient's condition would deteriorate if he were fully informed. A. 128.

On March 5, 1979 the district judge signed a Pretrial Order which first raised the claims against the transfers in issue in this proceeding. A. 157 ¶ II(J); A. 166-67 ¶ II(J).** Private physician and nursing home transfers

---

* The dissent on this issue interprets the regulations on which the majority relies differently and would permit a single notice to be provided by nursing homes or URCs A. 129-32. Section 205.10 (a)(4)(i) is read as requiring the state agency to retain only ultimate responsibility for timely and adequate notice of proposed action reducing or terminating Medicaid benefits, thus permitting any person or organization, whether public or private, to prepare and dispatch the notice. A. 130. Section 205.100(b) is read to foreclose the delegation of only discretionary acts to private parties, not the ministerial act of dispatching the state form notice with the URC notice. A. 130-31. Speaking in the alternative, the dissent describes the URC as a public agency (A. 130, 131-32), noting that § 205.100(b) would then have no foreclosing effect on its capacity to perform state-delegated tasks. A. 131-32.

** Extended discovery preceded the Pretrial Order. R.A. Doc. Nos. 35, 38-40, 44, 47, 48, 50-56, 60-63, 66-71. Over five hundred (500) URC decisions transferring patients to lower levels of care were produced (A. 198 ¶ XII [124]) and one hundred and fifty (150) fair hearings A. 204 ¶ XII (132). Ten (10) of the fair hearings (issued before December, 1978) considered the merits of URC transfers to higher levels of care. Petitioners objected to the production of patient records, other than those of the named respondents and intervenors, on the ground, *inter alia*, that they were confidential and privileged under federal and state law. R.A. Doc. Nos. 35, 61 pp. 3-6, 62 (McKay affidavit ¶¶ 3, 4). The district court responded to the objection by entering protective orders which limited access to patient records to respondents' and intervenors' attorneys and their assistants. R.A. Doc. Nos. 44 (second decretal paragraph); 56 (third decretral paragraph). See also R.A. Doc. No. 71 p. 3 (discovery sought subject to R.A. Doc. No. 44).

of Medicaid patients to different levels of care and URC transfers of these patients to higher levels of care were alleged to be improper under unspecified federal and state regulations prohibiting "arbitrary discharge" (A. 182 ¶ 61) and permitting nursing home transfers only for certain reasons which the Order did not set forth. A. 167 ¶ II(J)(b). They were also alleged to involve state action and to deprive patients of protected Fourteenth Amendment interests (transfers "down"—reduction or termination of Medicaid benefits; all transfers—"transfer trauma") if implemented without prior evidentiary hearings. A. 166-67 ¶ II(J).

The Pretrial Order describes the newly presented transfers only in terms of two of petitioners' policies then in effect. A. 180-82 ¶ IV. Patients transferred to different levels of care by private physicians and nursing homes were not entitled to fair hearings but could request one. A. 181-82 ¶ IV(60). If requested, the patient obtained the same rights, before and at the hearing, as a patient who contested a URC transfer to a lower level of care or to an adult home. A. 178-79 ¶ III(52); A. 181-82 ¶ IV(60).* Patients transfered to higher levels of care by URCs were not afforded fair hearings, at least since November, 1978 (A. 181 ¶ IV(57), (58[a]), and, since July, 1978, those URC decisions had been advisory, i.e. without prejudice to the patient's remaining at his pre-transfer level of care with corresponding Medicaid benefits in tact. A. 180

---

* The October 17, 1979 Partial Final Judgment, Stipulation of Consent, enlarged the rights of URC transferees to lower levels of care to include a patient veto over "out-of-facility" transfers. A. 231-32 ¶ II(F)(2); A. 232-33 ¶ III(B). Since petitioners' policy provided private physician and nursing home transferees with the same rights as URC transferees to lower levels of care if the former requested fair hearings, both groups of patients could veto transfers to different nursing homes or adult homes.

¶ IV(56).*

The original claims of the respondents and intervenors about transfers to lower levels of care and discharges to adult homes which were originally pleaded and determined in their favor by the preliminary injunction and first appeal (discussion pp. 8-13) were restated in the Pretrial Order. A. 154 ¶ II[B], [C]; A. 164 ¶ II [B], [C].** The action was described as a class action brought on behalf of all Medicaid-eligible residents in nursing homes (A. 150 ¶ A), and a new class was defined, consisting of "all residents of skilled nursing and heatlh related nursing facilities in New York State who are recipients of Medicaid benefits." A. 151 ¶ B. No new respondent, intervenor or class representative was joined.***

---

* The policies reflected the petitioners' informed judgment and were subject to their discretionary modification or repeal. For example, the policy permitting fair hearings for physician and nursing home transferees was under review when the Pretrial Order was signed. A. 181-82 ¶ IV (60). Petitioners' discretion in the premises was eliminated in the course of further proceedings in this case. Pre-transfer fair hearings were required, as a matter of constitutional right, for physician and nursing home transfers to different levels of care and for URC transfers to higher levels of care by the December 13, 1979 Partial Final Judgment (A. 242-43 ¶¶ 2, 4) and by the opinion and judgment on review A. 248-52. Voluntary tranfers, i.e those subject to patient veto, without prejudice to Medicaid benefits, were jeopardized by the discontinuance or reduction of FFP based on HEW's refusal to approve any state policy which gave Medicaid patients the choice of remaining at a level of care which was not URC prescribed. A. 217-20 ¶¶ 4-10. The October 17, 1979 Partial Final Judgment. Stipulation of Consent ¶ XIII (A. 236) and the opinion and judgment below (A. 252-53) respectively conditioned voluntary transfers and fair hearing rights on the judgment of HEW rather than of the petitioners.

** The original claim of entitlement to a state policy which would require nursing homes to provide both SNF and HRF care in a single facility (discussion, p. 9) was also restated. A. 152-53 ¶ I(B); A. 163-64 ¶ I.

*** The Pretrial Order included new claims in addition to those alleged against the transfers in issue herein. Medicaid patients

(footnote continued on following page)

Respondents and intervenors then moved for summary judgment on three distinct groups of claims. A. 209-11. The first group consisted of the claims against URC transfers to lower levels of care that were originally pleaded (except the claim involving SNF/HRF single facility care). See discussion, pp. 9, 15, second footnote. The entry of a Stipulation of Consent that had been executed by the parties (A. 229-36), or its equivalent, was sought. A. 209 ¶ 1(A)(1); A. 211 ¶ 1(B)(1). The Stipulation incorporated the relief previously awarded by the preliminary injunction (A. 232-33 ¶ III[A], [E]) and added certain substantive and procedural patient rights (A. 229-32 ¶ II; A. 232-33 ¶ III[A][2], [3], [B]-[D]), including

---

(footnote continued from preceding page)

transferred to lower levels of care were alleged to be entitled to: the assistance of trained patient representatives from notice of the URC decision and to counsel at fair hearings or other review proceedings, both at petitioners' expense; the presentation of a *prima facie* case at fair hearings, based on clear and convincing evidence, which would include proof that a URC physician had examined the patient and that no physical or psychological harm would result from the transfer; fair hearing decisions affirming URCs based on full review of transcripts and exhibits and precluding rejection of hearing officers' recommendations based on credibility; and independent review of URC decisions for at least facial or procedural defects by state or local public agencies. A. 153-57 ¶¶ II(A), (D), (E)-(H); A. 164-66 ¶¶ II(A), (D)-(H). Other claims which also were not originally pleaded alleged that to prevent bias and arbitrariness, a nursing home's URC physicians could not attend any patients in the home or any nursing home under the same management or ownership and that all URC and fair hearing procedures related to levels of care had to be promulgated as state rules or regulations. A. 157 ¶ II(I), (K); A. 166 ¶ II(I); A. 167 ¶ II(K). The claim about promulgation of procedures was determined, in part, in 1978 when the district court held that the numerical scoring system petitioners required URCs to use in conducting periodic reviews was a rule or regulation under state law (456 F. Supp. 653) and ordered it filed and promulgated accordingly. R.A. Doc. Nos. 59, 65. The claim about review of fair hearing transcripts and exhibits by the administrator affirming a URC transfer was decided with the claims against the transfers on review. See discussion, pp. 18, 19, 20.

a patient veto over URC transfers to lower levels of care and discharges "out-of-facility," i.e. to a different nursing home or to an adult home, which could be exercised without prejudice to the patients remaining at a higher level of care with the corresponding Medicaid benefits in tact. A. 231-32 ¶ II(F)(2); A. 232-33 ¶ III(B). It also listed issues which were reserved for future litigation (A. 234-35 ¶ VIII), including whether the transfers in issue in this proceeding involve state action and afford the affected patients a due process right to pre-transfer evidentiary hearings. A. 234-35 ¶ VIII(A)(1).* The presentation of the issue in this form eliminated claimed violations of federal and state regulations which were attributed to the transfers when they were first raised in the Pretrial Order. See discussion, pp. 13-14. On October 17, 1979, the district court granted the relief sought and adopted the Stipulation of Consent as a Partial Final Judgment. A. 227-28.**

---

* The claim of entitlement to a state policy requiring nursing homes to provide both SNF and HRF care in a single facility was also reserved for future litigation (A. 235 ¶ VIII[B][3]), and the district court has not yet been asked to address it. The claim for one million dollars ($1,000,000.00) in damages was not settled or reserved.

** Petitioners opposed the adoption of the Stipulation of Consent on the ground that the express conditions to its entry had not been met. A. 218 ¶ 4; A. 219-20 ¶ 8. That condition, set forth in the Stipulation at ¶ XIII (A. 236), states that "judicial approval . . . shall not be sought by the parties until . . . [HEW] represents, or it is judicially determined, that defendants' [petitioners'] compliance . . . will not cause . . . [FFP] in the New York State Medicaid Program to be terminated or reduced. . . ." Although the attorneys for parties had requested HEW to provide the required representation, HEW did not (and still has not). A. 218-20 ¶¶ 5-9. Its only response was that program-wide reductions of FFP for non-compliance, if any, would be prospective and that retroactive reductions for non-compliance, if any, would be limited to individual cases discovered by audit. A. 218-19 ¶ 6. Petitioners found HEW's response insufficient (A. 219-20 ¶¶ 7, 8), particularly in light of their understanding that HEW was likely to find the Stipulation's provision for a patient veto out-of-com-

(footnote continued on following page)

The second group of claims relied on the transfers of Medicaid patients to different levels of care by private physicians and nursing homes and to higher levels of care by URCs which were first raised in the Pretrial Order. See discussion, p. 13. Declaratory and injunctive relief was sought on the Fourteenth Amendment rights of these patients to pre-transfer evidentiary hearings (A. 209-10 ¶¶ 1[A][2][a], [A][3][b]), the question about the transfers reserved for future litigation in the October 17, 1979 Partial Final Consent Judgment, Stipulation of Consent ¶ VIII(A)(1). A. 234-35. See discussion, p. 17. Declaratory and injunctive relief was also sought on a third group of claims. A. 210 ¶¶ 1(A)(2)(b), (A)(3)(c). They alleged that the fair hearing procedures permitting the administrator who issued the final decision to reject a hearing officer's recommendation in favor of a patient without reading a verbatim transcript of the hearing and the exhibits were constitutionally insufficient and violated state law. *Ibid.**

Both the second and third groups of claims were opposed by petitioners and litigated before the district court. A. 223-26. No new respondent, intervenor or class representative was joined during the proceedings. On

---

(footnote continued from preceding page)

pliance. A. 220 ¶ 10; A. 221 ¶ 12. Petitioners then moved to join HEW as a party so that the agency's position on the Stipulation, as well as the other claims on the motion, could be established and litigated, if necessary. A. 221-22 ¶¶ 12 *et seq.*; R.A. Doc. No. 85. The motion was denied. R.A. Doc. No. 85 (memorandum endorsed on back). In so ruling, the district court apparently relied on the portion of paragraph XIII of the Stipulation, which relieves the petitioners from part, or parts, of the agreement which HEW subsequently finds to be out-of-compliance and assumed that any interim losses of FFP would be minimal. Petitioners did not appeal from the adoption of the Stipulation of Consent as a Partial Final Judgment.

* This third group of claims, like the second, was first raised in the Pretrial Order. See discussion, p. 15 second footnote.

October 17, 1979, the district court decided both groups of claims adversely to petitioners. The court's memorandum opinion endorsed states in full (A. 240):

> "The Court holds that as to both non-UR transfers out of a facility or to a lower level of care and as to UR transfers to higher levels of care there is a due process right to a hearing, state action being involved in both instances for all the reason[s] set forth in plaintiffs['] [respondents and intervenors'] memorand[a] on these question[s] and that it is settled law that a verbatim transcript is required."

A (second) Partial Final Judgment followed on December 13, 1979. A. 241.* The judgment certifies a new class, first described in the Pretrial Order (discussion, p. 15), of "all Medicaid recipients in the State of New York who are residents of skilled nursing facilities or health-related facilities" located in the state. A. 241-42 ¶ 1. The declaratory relief awarded in favor of pre-transfer hearings omits the opinion's out-of-facility limitation and decrees that petitioners' failure to provide advance written notice and opportunity for prior evidentiary hearings for nursing home transfers of Medicaid patients to higher or lower levels of care and for their discharges from nursing care violates the Due Process Clause of the Fourteenth Amendment. A. 242 ¶ 2. The injunctive relief on this point directs petitioners and all persons in active concert with them (including skilled nursing and health related facilities and their personnel) to enforce the declared hearing rights and requires the pre-transfer hearing to determine "the validity and appropriateness" of the transfer. A. 243 ¶ 4. The judgment also includes declaratory and injunctive relief on the transcript issues. A. 242 ¶ 3; A. 243 ¶ 5.

Petitioners appealed the December 13, 1979 Partial Final Judgment and the denial of their motion to join

---

* The December 13, 1979 Partial Final Judgment was not entered by the district court until February 19, 1980. A. 243.

HEW as a party. A. 244, 246.* The Court of Appeals affirmed the district court's holding that Medicaid patients transferred to different levels of care by their private physicians or nursing homes ("non-UR" or "non-URC" transfers [A. 241, 248]) and to higher levels of care by their URCs were entitled to pre-transfer evidentiary hearings under the Fourteenth Amendment. A. 248-52.** It modified the related injunction, which mandated written notice of and opportunity for prior hearings which would determine "the validity and appropriateness" of the transfers (A. 243 ¶ 4 and discussion, p. 19), by relieving petitioners of any obligation there stated which HEW found inconsistent with Medicaid program requirements. A. 246, 253, 259.*** The district court's holding on the transcript issue was found inconsistent with both federal and state law (A. 254-59), and the related portions of the judgment vacated. A. 246, 259.**** That Court's denial of petitioners' motion to join HEW was affirmed as not an abuse of discretion. A. 246, 252-53, 259.

---

* A stay of the judgment's hearing and transcript requirements pending appeal was requested from the district court (R.A. Doc. Nos. 106 [Skerrett affidavit, McGarvey affidavit]; 107 pp. 12-20) and denied. R.A. Doc. Nos. 114 ¶ 6; 115 pp. 13-14.

** The Court excluded URC transfers to lower levels of care from consideration, recognizing that the October 17, 1979 Partial Final Judgment, Stipulation of Consent (A. 227), had settled the question of permanent relief left open by the Court's earlier (January 16, 1979) opinion. A. 248.

*** Respondents and intervenors cross-petitioned for a writ of certiorari on this Court of Appeals ruling. Docket Number 80-6890. They argued that it was clear error for the Court to have conditioned the due process rights of Medicaid patients on federal statutory or regulatory program requirements. Petition, p. 5. The petition was denied. October 5, 1981 Order in Docket Number 6890.

**** Respondents and intervenors petitioned for a writ of certiorari on this Court of Appeals ruling. Docket Number 80-5791. The petition was denied on February 23, 1981. 450 U.S. 925.

According to the Court of Appeals, private physician and nursing home transfers of Medicaid patients to different levels of care and URC transfers of these patients to higher levels of care were within the Fourteenth Amendment because they involve state action and deprive the affected patients of protected interests in liberty and property. A. 248-51. State action sufficient to satisfy the nexus requirement described in *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974), is said to be present because Medicaid benefits are adjusted to conform with the level of care selected by the patient's physician, nursing home or URC. A. 249-50.* Any other basis for finding state action present is expressly disclaimed, and the identity and private character of the individual or group transferring the patient is said to be irrevelant. *Ibid.* As the Court observes (A. 250): "[A]n alteration in the patient's benefits . . . is the nexus required by *Jackson* v. *Metropolitan Edison*, and . . . that exists . . . despite . . . [any] change in identity of the party initiating the transfer. . . ." However, the Court appears to take another, or perhaps, alternative approach, in its discussion of state action, characterizing the decision of a physician, nursing home or URC about the level of care a Medicaid patient receives as, "in essence," a delegation of the state decision to increase or reduce a public assistance recipient's benefits "to a 'private' party," and finds that the delegation cannot prevent due process guarantees from attaching. A. 249. The first Court of Appeals opinion in this case is cited in support of this proposition (A. 126-27, pp. 12-13), although it prohibited state and local officials from delegating their obligation to notify Medicaid patients about reductions in benefits to nursing homes and URCs. *Ibid.* Patient transfers to higher levels of care are then found to involve protected interest in liberty because of the risk of transfer

---

* *Jackson's* finding of no state action is distinguished on the ground that the regulatory commission's failure to exercise its veto power in that case was "passive" 'inaction' whereas state Medicaid authorities in fact 'respond' to the choices of physicians, nursing homes and URCs when they adjust benefits. A. 249.

trauma, and transfer to lower levels of care, protected interests in property because of the consequential reduction or termination of Medicaid benefits paid on the patients' behalf. A. 250-51.* The Court concludes its review of the Fourteenth Amendment rights of Medicaid patients affected by the transfers in issue by finding that the pre-transfer evidentiary hearing required by the judgment on appeal (A. 242-43 ¶ 4) fairly defines the process that is due. A. 251-52.** At no point in the discussion of state action, the protected interests of the patients, or the procedures which satisfy due process does the Court consider whether any respondent, intervenor or class representative was transferred, or threatened with a transfer, to a different level of care by his physician or nursing home or to a higher level of care by his URC.

---

* The holding in *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980), that transfer trauma is not a protected liberty interest is distinguished on the ground that the injury to the patients in this case is more direct and the record in support of the existence of the condition, better. A. 251.

** The Court's acceptance of pre-transfer evidentiary hearings in this context depends, in part, on its understanding that the affected patients are entitled to essentially the same hearing right under federal and state statutes and regulations. A. 252. See also A. 246 and A. 253, citing 42 U.S.C. § 1396(a)(3) and 45 C.F.R. § 205.10. This view is mistaken. As the Court's own reference to the cited statute and regulation at A. 247 makes clear, the provisions refer to hearings on reductions or terminations of assistance, excluding the physician, nursing home and URC transfers to higher levels of care to which the judgment (A. 242-43 ¶ 4) and this proceeding are directed in part. In addition, neither HEW nor state social services officials consider medical transfers by physicians and nursing homes to lower levels of care, or discharges, the only "downward" transfers considered by the judgment and in issue in this proceeding, to be subject to statutory or regulatory fair hearing rights even though they result in reductions or terminations of benefits. See discussion, p. 6, second footnote.

Summary of Argument

The district court was without jurisdiction under Article III to find that state action was involved in private physician or nursing home transfers of Medicaid patients to different levels of care, or in URC transfers of these patients to higher levels of care. No respondent, intervenor or class representative complained that he had been transferred, or threatened with transfer, in this manner, much less that he suffered, or would suffer, the requisite "distinct" or "palpable" injury. *Gladstone Realtors* v. *Village of Bellwood,* 441 U.S. 91, 99 (1979). The classes certified by the district court, whether narrowly or broadly defined, did not cure this jurisdictional defect. Since none of the named respondents or intervenors, who purported to represent the class, established the requisite case or controversy with the petitioners, none could seek relief for himself or anyone else. *O'Shea* v. *Littleton,* 414 U. S. 488, 494 (1974).

The physician, nursing home and URC transfers in issue are medical decisions about the intensity of nursing care a patient needs. They are made by a patient's attending physician, a staff physician at his nursing home or these physicians' "peer review" committee, the URC. The Court of Appeals correctly identified them as private decisions for all patients at the time they are made, regardless of the manner in which the patients intended to pay their bills if they accepted the medical advice. A. 249-50. The Court then transformed the medical decisions into decisions of the state if the patients were Medicaid-funded *and* the decisions about their care produced conforming adjustments in benefits to meet their cost. The Court's reasoning in this regard and, in particular, its adoption of an adjustment in benefits rationale to find state action present, is foreclosed by *Jackson* v. *Metro-*

politan Edison Co., 419 U.S. 345 (1974), the only case cited in its support. Moreover, the incongruous results that flow from it are manifold. Because there is no certain relationship between change in cost and care, much less one with a "close nexus" to the state, medical decisions of minimal significance, like a change in a druggist's prescription, involve state action, while others of great significance, like a surgeon's refusal to perform a potentially life-saving operation on cancer patient, do not. Indeed, the Court of Appeals rationale does not even permit the patients to whom it is specifically directed the relief they sought, and the Court apparently intended them to have. Since the cost of nursing home care and the level of nursing home care are not synonymous, the transfer of a Medicaid from an SNF to a HRF of equal cost does not involve state action although the intensity, or level, of nursing care changes. In like manner, the transfer of a patient between SNFs of unequal cost, does involve state action although the level of nursing care remains the same. Both results are exactly at odds with what the Court of Appeals intended to achieve, the protection of state action for changes in levels of care.

POINT I

The district court did not have jurisdiction to determine whether state action was involved in private physician or nursing home transfers of Medicaid patients to different levels of care or in Utilization Review Committee transfers of these patients to higher levels of care. No respondent, intervenor or class representative complained that he was either transferred or threatened with transfer in this manner.

The jurisdiction of the federal courts is limited to "cases [and] . . . controversies." U. S. Const. art. III, sec. 2. *Flast* v. *Cohen*, 392 U.S. 83, 94 (1968). The requirement is satisfied only by a plaintiff who demonstrates to the district court that he has actually suffered a "distinct or palpable injury" or has been so threatened as a result of the action challenged. *Gladstone Realtors* v. *Village of Bellwood*, 441 U.S. 91, 99 (1979). See also, *H.L.* v. *Matheson*, —— U.S. ——, 101 S. Ct. 1164, 1169 (1981); *Warth* v. *Seldin*, 422 U.S. 490, 501 (1975); *O'Shea* v. *Littleton*, 414 U.S. 488, 493-4 (1974); *Roe* v. *Wade*, 410 U.S. 113, 128 (1973); *Flast* v. *Cohen*, *supra*, at 101. In this proceeding, the actions challenged and the basis for the finding of state action in the opinion below (A. 249-50) and in the district court memorandum opinion endorsed (A. 240) were private physician and nursing home transfers of Medicaid patients from one level of care to another and URC transfers of these patients to higher levels of care. However, no respondent, intervenor or class representative complained that he had been transferred or threatened with transfer in this manner, and as a result, no case or controversy was presented to the district court.*

---

* Article III defects in jurisdiction "may always be raised, even for the first time, at the Supreme Court level," L. Stern and

(footnote continued on following page)

The claims of the respondents and the intervenors were limited to URC transfers of Medicaid patients in nursing homes to lower levels of care and discharges from HRFs to adult homes. See discussion of the First Amended Complaint and the intervenor complaints at pp. 7, 8-10. Their claims were partially determined by the district court's preliminary injunction (A. 100-102 ¶ 2) which was affirmed, insofar as appealed, by the Court of Appeals in its first opinion in this case. A. 123, 125-129.* They were restated in the Pretrial Order (A. 154 ¶¶II [B], [C]; A. 164 ¶¶ II [B], II[C]), and finally determined by the October 17, 1979

(footnote continued from preceding page)

E. Gressman, Supreme Court Practice, 885 (5th ed. 1978) because "an actual live controversy must be extant at all stages of appellate or certiorari review, not merely at the time the complaint is filed. *Preiser* v. *Newkirk*, 422 U.S. 395, 401; *Steffel* v. *Thompson*, 415 U.S. 452, 459 n. 10; *Roe* v. *Wade*, 410 U.S. 113, 125; *SEC* v. *Medical Committee for Human Rights*, 404 U.S. 403; *United States* v. *Munsingwear, Inc.*, 340 U.S. 36." *Id.* 886.

* The preliminary injunction determined the claims of respondents and intervenors about notice to affected patients, to be provided by health or social services officials, of (a) the reasons for URC transfers to lower levels of care and corresponding reductions or terminations of Medicaid benefits, (b) fair hearing rights with aid continuing and (c) pre-hearing access to patient case files and medical records, including medically contraindicated information. A. 100-102 ¶ 2 (January 5, 1978 preliminary injunction order), A. 112-14 (January 10, 1978 preliminary injunction opinion) and discussion, pp. 10-11. Petitioners appealed from two aspects of the January 5, 1978 order: their obligation to provide a notice of the reasons for URC decisions and corresponding reductions of terminations of benefits which resulted in affected patients receiving two notices, one from their URCs or nursing homes, and one from the petitioners; and the patients' right of access to medically contraindicated information in their case files and medical records. A. 125-129 and discussion, pp. 11-13. The Court of Appeals affirmed the preliminary injunction in these respects. A. 123, 125-29.

Partial Final Judgment which was entered on consent. A. 232 ¶ III (A); A. 233 ¶¶ III (D), (E)).*

The transfers of Medicaid patients from one level of care to another by private physicians and nursing homes and to higher levels of care by URCs that are in issue in this proceeding were presented for the first time in the March 5, 1979 Pretrial Order (A. 157 ¶ II[J]; A. 163 ¶ 28; A. 166-67 ¶ II[J]; A. 180-182 ¶ IV) and due process (A. 163 ¶ 28; A. 180-82 ¶¶ 56, 57, 58, 59, 60, 61) and statutory violations of patients' rights there alleged, A. 157 ¶ II(J); A. 166-67 ¶ II(J). The question of whether state action was involved in these transfers was then stated and reserved for future litigation in the October 17, 1979 Partial Final Judgment (A. 234-35 ¶ VIII [A] [1]), although no respondent or intervenor complained that he had been, or would be, subject to any of these transfers, much less that he had suffered, or would suffer, a "distinct or palpable injury" as a result. *Gladstone Realtors* v. *Village of Bellwood, supra.* The district court determined the state action question as well as the related question of what process was due, while the case remained in this posture, namely without a party or any other representative be-

---

* The October 17, 1979 Partial Final Judgment made the preliminary injunctive relief permanent. A. 232 ¶ III(A); A. 233 ¶¶ III(D), (E). It also finally determined the claims of respondents and intervenors about the reliability and regularity of URC decisions on transfers to lower levels of care (First Amended Complaint A. 26-29 ¶¶ 25-35; A. 29-30 ¶¶ 36-39 and discussion, pp. 8-10) by establishing certain substantive and procedural constraints for URCs (A. 29-31) and fair hearings (A. 233 ¶ IV and discussion pp. 16-19) and by omitting those claims from the issues reserved for future litigation. A. 234-35 ¶ VIII. Respondents' claim of entitlement to nursing homes with multiple levels of care, the only claim pleaded in the First Amended Complaint and intervenor complaints (A. 30 ¶¶ 40-42) to survive the October 17, 1979 Partial Final Judgment, was reserved for possible future litigation A. 235 ¶ VIII(B)(3). It is immaterial to this proceeding since it has yet to be addressed by the district court. See discussion, pp. 9, 17.

fore the court who complained about the transfers on which the ruling relied (A. 240 [memorandum opinion endorsed]; A. 242-43 ¶¶ 2, 4 [December 13, 1979 Partial Final Judgment]), and the Court of Appeals affirmed in relevant part. A. 249-252. See discussion, pp. 13-15, 17, 18-22. Given the absence of a party with a personal stake in the outcome of the proceedings just described, the case or controversy requirement was never satisfied for the private physician, nursing home or URC transfers.

The classes certified during the proceedings below did not cure the deficiencies in Article III jurisdiction. The original December 13, 1977 certification defined a class of individuals who were, or would be, subject to URC transfers to lower levels of care, and discharges to adult homes. A. 45 ¶ 2. This class definition was consistent with the claims of the named respondents and intervenors.* The class claims were finally determined in the October 17, 1979 Partial Final Judgment, together with those of the named respondents and intervenors, and are moot. See discussion, pp. 25-26.

The March 5, 1979 Pretrial Order described a new, broader class, which was intended to support the private physician and nursing home transfers to different levels of care and URC transfers to higher levels of care, at issue in this proceeding, as well as other new claims

---

* The district court's January 10, 1978 certification of a subclass of individuals subject to URC transfers to lower levels of care, who had been denied adequate notice and access to documents and evidence prior to their fair hearings, (A. 118) was also consistent with the claims of the named respondents and intervenors.

raised in the Pretrial Order. A. 151 ¶ B and discussion pp. 15-16. The new class was incorporated in the December 13, 1979 Partial Final Judgment and defined as "all Medicaid recipients in the State of New York who are residents of skilled nursing facilities or health-related facilities in the State." A. 241-42 ¶ 2. No new respondent, intervenor or class representative was joined when the Pretrial Order was signed or entered and none was added before entry of the Partial Final Judgment. As a result, since the district court did not have before it any person with standing to raise the transfers at issue in this proceeding, the broader class definition could not cure the Article III jurisdictional defect. As the Court stated in *O'Shea* v. *Littleton, supra,* at 494, if none of the named respondents "purporting to represent a class establishes the requisite of a case or controversy with the defendants, none may seek relief on behalf of himself or any other member of the class." *Accord, Indiana Employment Division* v. *Burney,* 409 U.S. 540, 541-42 (1973); *Bailey* v. *Patterson,* 369 U.S. 31, 32-33 (1962).

The claims of the Grey Panthers, if any, were finally determined together with those of the original (December 13, 1977) class in the October 17, 1979 Partial Final Judgment.* The new class described in the Pretrial Order and incorporated in the December 13, 1979 Partial Final Judgment excluded the Grey Panthers relying exclusively on "residents of skilled nursing and health-related nursing facilities in New York State who are recipients of Medicaid benefits." A. 150 ¶ A; 151 ¶ B; 241-42 ¶ 2. Accordingly, the Grey Panthers was not a party in any of the proceedings which adjudicated the transfers on review.

Even if the Court finds that the Grey Panthers continued to be a viable respondent during the phase of the

---

* See p. 27 footnote.**

litigation in which the transfers in issue were adjudicated, their allegations did not present the district court with a case or controversy either in its own behalf or as a representative of its members. A. 21 ¶¶ 5, 6, 7. The Grey Panthers' allegations in its own behalf relied on the association's interests in quality health care and advocacy for its members. A. 21 ¶¶ 5, 7. These allegations amount to a mere interest which is not sufficient by itself to "render an organization 'adversely affected' or 'aggrieved'. . . ." *Sierra Club* v. *Morton*, 405 U.S. 727, 739 (1972). Moreover, the Grey Panthers did not allege that the association had any statutory or constitutional rights which were violated. A. 21 ¶¶ 5, 6, 7. Its claimed capacity to litigate the constitutional rights of its members required it to show that its members, standing alone, had the requisite personal stake to meet the case or controversy requirement. *Warth* v. *Seldin*, 422 U. S. 490, 511 (1975). An "association must allege that its members, or any one of them, are suffering immediate or threatened injury as a result of the challenged action of the sort that would make out a justiciable case had the members themselves brought suit." *Ibid.*, quoting *Sierra Club* v. *Morton*, *supra* at 734-741. The Grey Panthers did not show that any of its members were transferred or threatened with private physician or nursing home transfers to a different level of care or URC transfers to a higher level of care. A. 21 ¶¶ 5, 6, 7. This Court's recent decision in *Grey Panthers* v. *Schweiker*, —— U.S. ——, 101 S. Ct. 2633, 2638, n. 8 (1981), permitting the Grey Panthers to raise the constitutional rights of its members, is not opposed. There, the Grey Panthers "alleged and proved that some of its members are [were] persons adversely affected. . . ." (*Ibid.*), exactly the proof missing in this case.

POINT II

Decisions by private physicians and nursing homes to transfer Medicaid patients to different levels of care and by utilization review committees to transfer these patients to higher levels of care do not become decisions of the State because the patients' benefits are increased or decreased, when warranted, to reflect differences in the cost of care.

The Court of Appeals found state action involved in the patient transfers in issue for only one reason—the adjustment in Medicaid benefits that follows a change in the level of nursing home care, or transfer, prescribed by a physician, nursing home or URC. A. 249-50. Two legal theories were offered to support the finding that state action was present. First, the "close nexus" between state and private action required by *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 351 (1974), was said to be satisfied because the state "responds to" (A. 249) the decisions of the medical professionals when Medicaid authorities increase or decrease benefits to accommodate differences in the cost of care that result from the transfers. A. 247, 249-50. Second, the decisions of the medical professionals were said to be state-delegated decisions to increase or decrease benefits because they determined whether a conforming adjustment in Medicaid benefits would be made. The first theory is foreclosed by *Jackson* v. *Metropolitan Edison Co., supra,* the case the Court of Appeals relied on, and the second theory, by *Flagg Brothers, Inc.* v. *Brooks,* 436 U.S. 149 (1978).

The adjustment in benefits rationale adopted by the Court of Appeals does not evidence the "nexus" between state and private action with respect to the patient transfers in issue required by *Jackson,* and the state's involve-

ment in the transfers is both less than and distinguishable from that presented by the utility commission's approval of the tariff considered in that case. *Jackson* describes the required relationship between the state and the private party as follows (419 U.S. at 351): "[T]he inquiry must be whether there is a sufficiently close nexus between the State and the challenged action of the regulated [private] entity so that the action of the latter may be fairly treated as that of the State itself." As appears, the state action component of the private entity's conduct must be "the challenged action" or the subject matter of the complaint. *Powe* v. *Miles*, 407 F.2d 73, 81 (2d Cir. 1968) (FRIENDLY, C.J.); *Grossner* v. *Trustees of Columbia University*, 287 F. Supp. 535, 548 (S.D.N.Y. 1968). See *Burton* v. *Wilmington Parking Authority*, 365 U.S. 715, 725 (1961). Under the Court of Appeals analysis in this case, it is not.

Respondents and intervenors do not complain about adjustments in their Medicaid benefits to meet the cost of their medical care, the only nexus between state and private action identified by the Court of Appeals. A. 249-50. They complain about the medical care itself, specifically the change in the level of nursing home care prescribed for them by their physicians, nursing homes and URCs. These medical decisions, which the Court of Appeals analysis accepts as private and free of state action in the first instance, are not "fairly treated" as acts of the state under *Jackson, supra*, because Medicaid authorities adjust the patients' benefits to meet the increased or decreased cost of the prescribed care. First, the adjustment in benefits is not an "action of the [private] entity," and respondents and inteverors do not 'challenge' it. Second, the adjustment in benefits has no effect on, or "nexus" with, "the action of the [private] entity" that is "challenged," namely the medical decisions that prescribe different levels of nursing home care, and those decisions therefore cannot be attributed to the state. The adjustment in benefits has no effect on the medical decisions

because it accepts the decisions in tact, without review of their merits or redetermination of their "validity or appropriateness." December 13, 1979 Partial Final Judgment, A. 243 ¶4(b). It provides only a conforming response, addressed to what the decision cost, an act which, as noted, is not challenged, is not the act of the private entity which is intended to be attributed to the state and is without effect on the acts complained of.

The Court of Appeals distinguished the no state action finding in *Jackson* on the ground that the state utility commission's approval of the tariff in that case was more "passive" than the Medicaid authorities' response in adjusting benefits to conform with the medical decisions of physicians, nursing homes and URCs about level or nursing home care their patients should receive. A. 249. The distinction finds no suport in *Jackson*, and the involvement of the state in the transfers in issue is less than was presented by the state utility commission's approval of the tariff in that case.

In *Jackson*, the Court set forth its reasons for refusing to find state action involved in the state utility commission's approval of a tariff which authorized the termination of customers' electrical service for nonpayment without a prior hearing (419 U.S. at 357):

> "Approval of [a termination of service provision] . . . from a regulated utility, where the commission has not put its own weight on the side of the proposed practice by ordering it, does not transmute a practice initiated by the utility and approved by the commission into 'state action.'"

Accord, *Flagg Brothers, Inc.* v. *Brooks, supra,* at 164, quoting text and describing it as supporting the Court's position that a state's mere acquiescence in private action does not convert that action into state action. *Flagg, supra,* at 164-65, notes further that the device of characterizing state inaction as authorization or encourage-

ment of private action so as to permit the imposition of Fourteenth Amendment restraints on the private action has been clearly rejected.

The application of this reasoning to the tranfers in issue must result in a finding that there is less state involvement in them than was present in the state utility commission's approval of the tariff in *Jackson*. According to the Court's opening remark in the text quoted above, the utility commission had approved the tariff, or at least had the power to approve or disapprove it on its merits. See also 419 U.S. at 354-55. Medicaid authorities do not exercise any similar power of "approval" with respect to physician and nursing home transfers to different levels of care and URC transfers to higher levels of care.* Nor do they put their "weight on the side of" the transfers by "ordering" them. As described above, the adjustment in benefits leaves the medical decisions in tact, without altering their form or substance, addressing them only in terms of their consequential cost. If the Medicaid patient were obliged to accept the prescription of his physician, nursing home or URC after the adjustment was made, the result in terms of state action analysis

---

* Indeed, there is grave doubt that Medicaid authorities have the power to address the merits of medical decisions to transfer patients by determining their "validity and appropriateness" (A. 243 ¶ 4[b]) in the course of adjusting benefits. As the Court recognized in *Planned Parenthood of Missouri* v. *Danforth*, 428 U.S. 52, 60 (1976), the state is without power to countermand the private medical choices of its citizens, at least in the absence of a clear threat to the public health, safety or welfare. Accordingly, it cannot have recourse to the device of increasing, decreasing or denying Medicaid benefits for that purpose. In the one circumstance, URC transfers to lower levels of care, in which Medicaid authorities in New York do determine the "validity and appropriateness" of medical decisions to transfer patients in the course of adjusting benefits, they were required to do so by HEW over their objection. See discussion, p. 6 footnote.

would be "mere acquiescence" of the state in the 'authorized,' or lawful, conduct of the physician, nursing home or URC, an insufficient basis for finding state action present. *Flagg Brothers, Inc.* v. *Brooks, supra; Jackson* v. *Metrolopitan Edison Co., supra.* However, he is not. Like any privately-funded patient, he may reject the medical advice he has been given and refuse the care. The only constraint on his choices is the same constraint faced by the privately-funded patient. He cannot obtain a medical service or level of care that a physician, nursing home or URC finds inconsistent with professional standards to provide.

The Court of Appeals alternative use of its adjustment in benefits rationale to find state action present in the transfers in issue because the medical decisions which prescribe them are, "in essence," state-delegated decisions to increase or decrease Medicaid benefits (A. 249) fairs no better than the use of that rationale under *Jackson.* Again, the Court confuses the decisions that are in issue with those that are not and confuses their effect on each other. The medical decisions about which respondents and intervenors in fact complain are made by physicians, nursing homes and URCs who, as the Court of Appeals recognized in both its opinions in this case, are private parties performing their traditional functions. A. 126 (January 16, 1979 Court of Appeals Opinion); A. 249-50 (opinion and judgment below). See discussion, pp. 12-13, 21. These decisions are not associated with the state at all, much less with a traditional or an exclusive function of sovereignity which would have to be present to support a finding in favor of state action on a delegation theory. *Flagg Brothers, Inc.* v. *Brooks, supra,* at 157-64 (refusng to find state action present in a warehouseman's execution of a lien and generally limiting the recognition of state action in private conduct, based on the delegation of state duties, to the performance of functions exclusively associated with government or sovereignity, e.g. elec-

tions, tax collection and municipal management); *id.*, at 171-79 (OPINION of STEVENS, J., dissenting and taking principal issue with the majority's refusal to include non-sovereign functions in the state action delegations it would recognize, a matter not here relevant). See *Schlein* v. *Milford Hospital, Inc.*, 516 F.2d 427, 429 (2d Cir. 1977); *Barrett* v. *United Hospital*, 376 F. Supp. 791, 799 (S.D.N.Y. 1974), *aff'd mem.* 506 F.2d 1395 (2d Cir. 1974); *Wagner* v. *Scheltz*, 471 F. Supp. 903, 907 (D. Conn. 1979); *Fuzie* v. *Manor Care, Inc.*, 461 F. Supp. 689, 695 (N.D. Ohio 1977); *Fried* v. *Straussman*, 41 N.Y. 2d 376, 376 (1977), all holding that while private and voluntary hospitals and nursing homes were affected by the public interest, they do not perform public functions traditionally associated with sovereignty. See also *Jackson* v. *Metropolitan Edison Co.*, *supra*, at 353-54.

The adjustment in benefits, about which respondents and intervenors do not complain, has no effect on the medical decisions transferring them (discussion, pp. 32-33, 34) and is not delegated. It is retained by the state Medicaid authorities and performed by them directly. This practice is required by the Medicaid program which includes adjustments in benefits in the determination of "the extent of medical assistance," 42 U.S.C. § 1396a(a)(17), a matter assigned to the single state agency and the public agencies it designates, not to private parties. The Court of Appeals relied on this principle of non-delegability of certain Medicaid program functions to private parties in its first opinion in this case. A. 126-28 and discussion, pp. 12-13. The Court then prohibited state Medicaid authorities from delegating the preparation and dispatch of patient notices about reductions in benefits and fair hearing rights on URC transfers to lower levels of care to physicians, nursing homes and URCs, describing them as private parties who were precluded from performing that public task by federal Medicaid regulations. *Ibid.* When the Court articulated its adjustment in benefits rationale

in the opinion and judgment on review, it nonetheless found that the same private parties had been delegated, and were free to perform, the more significant program function of adjusting patients' benefits. A. 125-27 and discussion, p. 21.

The rejection of the Court of Appeals finding that state action is involved in the transfer decisions in issue does not disadvantage Medicaid patients. It simply, and properly, discounts the source of their funding, leaving them with exactly the same rights and remedies as non-publicly assisted patients. In addition, the rejection of Court of Appeals ruling has salutary consequences for the Medicaid program. The judgments of the medical professionals are restored to the determinative position Medicaid intends them to have. See *Szekely* v. *Florida Medical Association.* 517 F.2d 345, 348 (5th Cir. 1975); *Rush* v. *Parham,* 440 F. Supp. 383, 388-91 (N.D. Ga. 1977). State Medicaid authorities are, in turn, relieved of the obligation to determine the "validity and appropriateness" (A. 243 ¶ 4[b]) of prescribed medical treatment, a matter outside Medicaid program requirements, and not the intended subject matter of fair hearings.

In contrast, the affirmance of the Court of Appeals finding results in extraordinary analytical and practical incongruities. Under the Court of Appeals adjustment in benefits rationale, decisions of Medicaid providers become "state action" decisions because they increase or decrease cost (and therefore benefits) without regard to their significance to the patient or to the state. Thus, the decision of a physician to change his patient's prescription from a "brand name" drug to a generic drug becomes a decision of the state because it minimally decreases cost. A decision of a physician to continue a cancer patient on chemotherapy does not, because cost (and benefits) continue to be the same. However, if the physician had decided, or decides in the future, that the same patient

should have surgery (increased cost, increased benefits) or should be withdrawn from chemotherapy (decreased cost, decreased benefits), his decision would involve state action. Notably, if the surgeon selected to perform the operation in the example above refused to do it, whether for arbitrary or medical reasons (and the patient were continued on this prior chemotherapy), no state action would be involved, because cost (and benefits) would remain the same. If the surgeon performed the operation, again whether for arbitrary or medical reasons, state action would be involved because cost (and benefits) would increase.

Indeed, under the Court of Appeals rationale, the class of Medicaid patients respondents and intervenors purport to represent do not obtain the relief they seek, and the Court intended to provide, namely the protection of state action for changes in levels of nursing home care, and discharges from that kind of care.

In New York, reimbursement rates for patient days (equivalent to the benefits paid on a Medicaid patient's behalf) are established for each individual SNF and HRF. PHL § 2807(3); 10 N.Y.C.R.R. Subpart 86-2; *Sigety* v. *Ingraham*, 29 NY 2d 110 (1971). Although rates for HRFs are "generally lower" than rates for SNFs (A. 169 ¶ 1[12]; A. 247), SNF and HRF rates vary within their respective classifications and across classifications. Thus, the rate of one HRF can be more, or less, than another, as can the rate of one SNF in comparison to another. Equally, the rate of an HRF can be the same as, or higher than, the rate of any SNF, and the rate of any SNF, the same as, or lower, than any HRF. As appears, this variable rate structure confounds the Court of Appeals adjustment in benefits rationale and disassociates a finding that state action is present from changes in the levels of care, the protective purpose the Court of Appeals intended it to have. The point is illustrated by the following patient transfers:

1) SNF to SNF, difference in rates/benefits, no difference in level of care—no state action present;

2) SNF to HRF, no difference in rates/benefits, difference in level care—no state action present;
3) HRF to SNF, no difference in rates/benefits, difference in level of care—no state action present"; and
4) HRF to HRF, difference in rates, no difference in level of care—state action present.

CONCLUSION

For the foregoing reasons, the Judgment below should be vacated as entered without jurisdiction, or, alternatively, it should be reversed, and physician and nursing home transfers of Medicaid patients to different levels of care and discharges from care as well as utilization review committee transfers of Medicaid patients to higher levels of care should be declared free of state action under the Fourteenth Amendment.

Respectfully submitted,

Robert Abrams
Attorney General of the State of
New York
Attorney for Petitioners
Two World Trade Center
New York, N.Y. 10047
(212) 488-2462

Dated: New York, New York
December 4, 1981

Shirley Adelson Siegel
Solicitor General

Judith A. Gordon
Andrea G. Iason
Assistant Attorneys General
*of Counsel**

---

* The Attorney General gratefully acknowledges the assistance of Joseph C. Bierman, Associate Counsel, New York State Department of Health, and Sheryl Krongold, Legal Assistant, New York State Department of Law, in the preparation of this brief.

(SEAL)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
REGION 1

JOHN F. KENNEDY FEDERAL BUILDING
GOVERNMENT CENTER
BOSTON, MASSACHUSETTS 02203

SOCIAL AND REHABILITATION
SERVICE

In reply refer to: SRS/MS #76-4

To: ALL STATE PUBLIC WELFARE ADMINISTRATORS
ATTENTION: STATE MEDICAL CARE DIRECTORS

SUBJECT: Title XIX—Fair Hearings—Requirement for Advance Notice and Continuation of Assistance —45 CFR 205.10(a)(5) and Fair Hearing Guides 6-30-20E and F

This letter is in response to inquiries from several States about the applicability of the "advance notice" and "continuation of assistance" requirements in the fair hearing regulation (45 CFR 205.10(a)(5)) to medical assistance programs under Title XIX.

Questions most frequently asked on these topics relate to a recipient's rights to advance notice and continuation of assistance by the agency when he is aggrieved by an agency action affecting suspension, reduction or termination of such assistance; for example, when he is found no longer to need skilled nursing home care or a particular kind of medication. The questions relate specifically to actions resulting from utilization review programs.

The "advance notice" and "continuation of assistance" requirements are not applicable when the change is prescribed by the patient's physician, because a physician's decision that his patient does or does not need a specified

type of medical care or service is not a decision of the medical assistance agency.

Utilization review committees are required to safeguard against unnecessary utilization and improper payment for care and services. They make recommendations about the appropriateness of care but do not issue orders for patients. Any utilization review recommendation differing from a current treatment program should be immediately referred to the attending physician.

a. Subsequent action by the physician whether or not in conformity with the utilization review recommendation is not agency action and the patient who disagrees with the physician's decision is not entitled to "advance notice" and "continuation of assistance."

b. Differences between the utilization review recommendation and the attending physician that cannot be reconciled may result in an agency decision to discontinue payment. The requirements of advance notice and continuation of assistance are applicable.

The medical assistance agency is obliged to give advance notice of any action it proposes to reduce, suspend, or terminate payment for medical services under the plan, when factors other than medical need are involved. This would apply when the agency has information that indicates that the recipient no longer meets one or more eligibility requirements; for example, that his income or resources have increased so that he is no longer eligible or that his financial eligibility s reduced.

While the individual has a right to a fair hearing in financial and medical assistance under circumstances identified in 45 CFR 205.10(a)(3), a change in medical care ordered by the patients physician does not represent an *agency proposal* to terminate, suspend or reduce the assistance payment. If a patient disagrees with his physician's determination of "medical necessity" for a specific service,

his recourse is to the practitioner or his professional association, not to the medical assistance agency.

When there has been a professional judgment that a specific medical service is no longer medically necessary, it is not expected that the agency will immediately cease to be obligated to pay for the previously needed service. Federal sharing in the cost of the service may continue for a reasonable period while other care is being arranged. The medical assistance agency (or another agency with which it has arranged for social services) should assist the recipient in obtaining the type of care that is professionally recommended, from a provider of his choice (45 CFR 249.11).

The rights of a provider of services to payment for care provided to an individual eligible for medical assistance after such care has been professionally determined not to be necessary depend on State law and agency policy. In cases of controversy, the issue must be resolved as one between the provider and the agency, not one between the recipient of medical assistance and the medical assistance agency.

Sincerely yours,

ALFRED G. FUOROLI
Alfred G. Fuoroli

Associate Regional Commissioner
for Medical Services

No. 80-1952

Office - Supreme Court, U.S.
FILED
JAN 20 1982
ALEXANDER L. STEVAS
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1981

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, M.D., as Commissioner of the New York State Department of Health,
Petitioners,

v.

WILLIAM YARETSKY, RALPH CUEVAS and THE GRAY PANTHERS, NEW YORK CHAPTER, *Respondents,*

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,
Intervenors-Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Second Circuit

---

BRIEF FOR RESPONDENTS

KALMAN FINKEL
Attorney-in-Charge
The Legal Aid Society
Civil Division

JOHN E. KIRKLIN
Director of Litigation
The Legal Aid Society
Civil Appeals & Law Reform Unit
11 Park Place, 8th Floor
New York, New York 10007
(212) 227-2755
[Counsel of Record]

DAVID GOLDFARB
Attorney-in-Charge
The Legal Aid Society
Bronx Neighborhood Office

CHARLES ROBERT
91 North Franklin Street
Room 205
Hempstead, New York 11550

Attorneys for Respondents

PRESS OF BYRON S. ADAMS PRINTING, INC., WASHINGTON, D.C.

QUESTIONS PRESENTED

1. Does the issue of whether there is state action in a nursing facility's discharge or transfer, without a hearing, of a Medicaid patient present a justiciable controversy where the named respondents were threatened with summary discharge or transfer by their facilities following the non-enforcement of Utilization Review Committee determinations to discharge or transfer them, and where the pleadings were amended by agreement of the parties to present the issue?

2. Does state action attach to a nursing facility's summary discharge or transfer of a Medicaid patient when New York State exercises direct and comprehensive control over the very conduct in question, the State maintains a unique mutually interdependent relationship with nursing facilities, and the facilities discharge important public functions?*

---

*Respondents submit that this question subsumes the non-constitutional issue of whether patient hearing rights under federal and state law attach to facility discharges or transfers of Medicaid patients.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
STATEMENT OF THE CASE	1
STATUTORY AND REGULATORY SCHEME	7
SUMMARY OF ARGUMENT	15
ARGUMENT	18
POINTS:	
I. The Case Presents A Justiciable Controversy	18
II. State Action Attaches To A Nursing Facility's Discharge Or Transfer Of A Medicaid Patient	21
A. Nexus between State and nursing facility conduct	23
B. Symbiotic relationship between State and nursing facility and facility's exercise of public functions	28
III. A Medicaid Nursing Patient Has A Right Under Federal And State Law To A State Agency Hearing When The State Takes Action To Adjust His Benefit Level Based On A Facility's Patient Discharge Or Transfer To A Lower Level Of Care	33
CONCLUSION	35

TABLE OF AUTHORITIES

CASES: Page

Burton v. *Wilmington Parking Authority*, 365 U.S. 715 (1961) 18, 28, 29, 30, 31, 32

Crowell v. *Bensen*, 285 U.S. 22 (1932) 33

Flagg Brothers, Inc. v. *Brooks*, 436 U.S. 149 (1978) 17 24, 25, 27

Fuentes v. *Shevin*, 407 U.S. 67 (1972) 27

Gladstone, Realtors v. *Village of Bellwood*, 441 U.S. 91 (1979) 16, 18

Jackson v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974) . 17 24, 25, 29, 30

Joy v. *Daniels*, 479 F.2d 1236 (1 Cir. 1973) 32

Kane v. *Perry*, 41 N.Y.2d 1051 (1977) 34

Lopez v. *Henry Phipps Plaza South, Inc.*, 498 F.2d 937 (2 Cir. 1974) 32

McQueen v. *Drucker*, 438 F.2d 781 (1 Cir. 1973) 32

Marsh v. *Alabama*, 326 U.S. 501 (1946) 30

Matter of Lee v. *Smith*, 43 N.Y.2d 453 (1977) 30

Memphis Light, Gas and Water Division v. *Craft*, 436 U.S. 1 (1978) 29

Moose Lodge No. 107 v. *Irvis*, 407 U.S. 163 (1972) 17 24, 25, 29

North Georgia Finishing, Inc. v. *Di-Chem, Inc.*, 419 U.S. 601 (1975) 27

O'Bannon v. *Town Court Nursing Center*, 447 U.S. 773 (1980) 26, 33

Polk County v. *Dodson*, 50 U.S.L.W. 4077 (December 14, 1981) 17, 24, 25

Public Utilities Commission v. *Pollack*, 343 U.S. 451 (1952) 26

Sniadach v. *Family Finance Corp.*, 395 U.S. 337 (1969) .. 27

Teitelbaum v. *Sorenson*, Civ. No. 79-199 PHX WEC (D. Ariz, March 16, 1979) 30

Traux v. *Raich*, 239 U.S. 33 (1915) 16, 20

Tucker v. *Toia*, 43 N.Y.2d 1 (1977) 30

United States v. *Rumely*, 345 U.S. 41 (1953) 33

Table of Authorities Continued

Page

United States v. *SCRAP*, 412 U.S. 669 (1973) 19

United States Parole Commission v. *Geraghty*, 445 U.S. 388 (1981) 16, 18, 21

Yaretsky v. *Blum*, 592 F.2d 65 (2 Cir. 1980) 2, 31

FEDERAL CONSTITUTION:

Article III 18, 21

Fourteenth Amendment 4, 16, 23

FEDERAL STATUTES:

42 U.S.C. § 1395 et seq. 8, 9

§ 1396 et seq. 7, 9, 10, 11, 12, 13

FEDERAL REGULATIONS:

42 C.F.R. § 405.120 et seq. 23

§ 405.1120 et seq. 11, 23

§ 405.1130 et seq. 9, 11, 32

§ 420.100 et seq. 11

§ 431.10 et seq. 11, 12

§ 431.200 et seq. 15, 34

§ 435.400 et seq. 12

§ 435.900 et seq. 12, 15

§ 440.40 et seq. 23

§ 440.200 et seq. 11

§ 442.1 et seq. 11

§ 442.200 et seq. 11, 13, 23

§ 442.300 et seq. 8, 9, 11, 13, 23

§ 447 13

§ 456.200 et seq. 8, 12

§ 456.300 et seq. 8, 12, 32

§ 456.400 9

§ 456.600 et seq. 10

Table of Authorities Continued

Page

FEDERAL RULES:

Federal Medical Assistance Manual, § 5-60-20 . 8, 9, 10, 12, 23
§ 5-100-20 15
§ 60-90-20 11

STATE CONSTITUTION:

Article 17 §§1 and 3 30

STATE STATUTES:

New York Public Health Law § 2800 et seq. 11, 14, 23
New York Social Services Law, § 22 15
§ 65 12
§ 364 11
§ 366 12
§ 367 ..... 11, 12

STATE REGULATIONS:

10 N.Y.C.R.R. § 414 ..... 11, 12, 23
§ 415 ..... 8, 9, 12
§ 416 ..... 8, 9
§ 420 ..... 8, 9
§ 421 ..... 8, 9
§ 704 9
§ 730 ..... 8, 9, 12, 15, 23
§ 731 ..... 8, 9, 12
§ 740 ..... 8, 9, 12, 23
§ 741 ..... 8, 9, 12
§ 742 11
18 N.Y.C.R.R. § 351 ..... 13, 15
§ 355 15
§ 358 ..... 13, 15, 34
§ 360 ..... 12, 15

Table of Authorities Continued

Page

§ 505 ..... 9, 10, 11, 12
§ 515 11
§ 516 11
§ 540 ..... 11, 12

STATE RULES:

New York State Department of Health:
Health Facilities Memorandum 79-23 12
79-47 9
80-54 10

New York State Department of Health:
Hospital Memorandum 76-135 12
77-9 ..... 10, 23
77-10 ..... 10, 12, 23
77-13 ..... 10, 23
77-35 12
77-60 ..... 10, 12
77-74 ..... 9, 10, 12

New York State Department of Social Services Administrative Directive 78-31 9

OTHER AUTHORITIES:

Patricia A. Butler, *Public Reimbursement of Nursing Homes — A Technical Guide for Resident Advocates* (Research Institute on Legal Assistance, Legal Services Corporation, 1980) 13, 14, 15, 29

Comptroller General's Report to the Congress, "Entering a Nursing Home — Costly Implications for Medicaid and the Elderly" (November 26, 1979) 29

Bruce Spitz, *Medicaid Nursing Home Reimbursement in New York* (The Urban Institute Press, 1980) 13, 14, 15, 29

STATEMENT OF THE CASE

Petitioners' brief presents, for the most part, an objective and accurate statement of this case. However, a more extensive recitation of how the issues presented in this Court developed during the course of the litigation is necessary, particularly for a complete understanding of the justiciability question which petitioners have raised here for the first time.

From the beginning of this suit the respondents' challenge has been to the illegal discharge or transfer of Medicaid patients out of the skilled nursing facilities (hereinafter "SNFs") or the intermediate care facilities[1] (hereinafter "ICFs") in which they reside. In the First Amended Complaint and the three Intervenor Complaints, respondents, on behalf of themselves and a class of Medicaid patients, complained about those discharges or transfers insofar as they resulted from erroneous adverse determinations of Utilization Review Committees (hereinafter "URCs") that Medicaid patients no longer needed their current level of care and the affirmance of those determinations by the State Department of Social Services. The specific injury alleged in the complaints by each of the three original respondents (including the organizational respondent The Gray Panthers, New York Chapter, on behalf of its 5,000 members) and the ten intervenor-respondents[2] was their involuntary and illegal discharge or transfer from their nursing homes. (A. 21, 26, 27, 32, 53, 60-61, 64-5, 67-8, 70-71, 79, 82, 85, 88, 91).

The intervenor-respondents obtained temporary restraining orders against both petitioners and the proprietors and managers of their nursing homes enjoining their discharge or transfer

---

[1] Intermediate care facilities are termed health related facilities, or HRFs, in New York State. (A. 168). References preceded by "A." are to the joint appendix in this case.

[2] Intervenor-respondent Pauline Ashkenazy has died since the time petitioners filed their petition for a writ of certiorari in this case.

from their facilities through implementation of the adverse URC determinations and State hearing decisions. (A. 41-2, 45-6). Following an evidentiary hearing and a written decision of the District Court, respondents obtained a preliminary injunction dated January 5, 1978 enjoining both petitioners and the proprietors and administrators of all SNFs and ICFs in New York State from discharging or transferring respondents and class members [3] out of their nursing facilities without minimal procedural safeguards. The preliminary injunction was affirmed by the Court of Appeals. 592 F.2d 65 (1979). (A. 99, 104, 122).

Subsequently, over the course of many months, attorneys for the respondents and petitioners negotiated a partial consent agreement, signed by the parties on May 29, 1979 and approved by the Court on October 19, 1979, which substantially improved the procedural protections for Medicaid nursing patients subjected to URC determinations to discharge them or transfer them to a lower level of care and which prohibited the implementation of such determinations unless voluntarily consented to by the patient. Over the course of these negotiations there were brought to the attention of respondents' attorneys several cases of facility threats, outside of the utilization review (UR) process, to summarily discharge Medicaid nursing patients. These particular threats were forestalled by the fortuitous intervention of legal services attorneys or representatives of the New York City Nursing Home Ombudsman Program, but they emphasized the very real danger, independent of the URC process and particularly if the URC route to involuntary patient moves were closed by agreement of the parties, that facilities themselves would initiate the involuntary discharge of patients.

---

[3] The class had been certified to include all Medicaid patients in SNFs and ICFs in New York State who are subjected to adverse URC determinations and state hearing decisions that they are ineligible to remain in their current facilities. (A. 45).

The named respondents (including members of the respondent Gray Panthers) and the intervenor-respondents were, in particular, under an especially grave threat of facility-initiated discharge or transfer, without hearing safeguards. Once URC transfers were no longer possible, respondents' facilities would be armed with permanently unenforceable determinations by URC physicians that these patients were inappropriately placed there and should be discharged or transferred elsewhere. Those adverse URC determinations were based on completion of the State-created and State-prescribed long-term care assessment form, called the DMS-1, and they had been specifically affirmed by the State. Thus, the facilities themselves, instead of the URCs, now posed the threat of causing respondents the precise injury they had alleged in their complaints — their arbitrary and erroneous discharge or transfer from their nursing homes, this time without even the opportunity for a hearing.

Petitioners themselves acknowledged the dangers inherent in involuntary patient transfers, whatever their origin. Thus petitioners admitted, in their attorney's affidavit in the District Court, that they had agreed to permanently halt implementation of involuntary URC determinations because of the devastating and unpredictable patient trauma that accompanies any involuntary out-of-facility move:

> Defendants agreed to the inclusion of the provision regarding the necessity of patient consent to transfer for two reasons. First, there exists a widespread phenomena known as "transfer trauma" which is the anxiety experienced by an elderly patient when moved from or even faced with the threat of being moved from a nursing home which he has come to view as his home to another institution. Further, it appears that transfer trauma can cause a deterioration of the patient's health leading in some cases to his death. Secondly, it appears that there is at present no way to know which patients object to being transferred out of a facility will suffer from transfer trauma and which will not.

> Therefore, the State defendants concluded that, given the current state of medical understanding of transfer trauma, the only way to protect the patient's health is to require that he consent to any proposed out-of-facility transfer.

(A. 220-21).[4]

In joint recognition of the threat that after the halting of URC transfers nursing facilities would involuntarily move Medicaid patients on their own initiative, petitioners and respondents stipulated in the Joint Pre-Trial Order, signed by the District Court on March 5, 1979, to the formal addition of respondents' claims challenging these facility actions, to a statement of petitioners' policies regarding the facility actions, and to an amendment of the class definition. Thus the parties stipulated to the assertion of respondents' claims that patient discharges and transfers to a lower or higher level of care performed by facilities or their agents outside of the URC review process and facility transfers to a higher level of care pursuant to URC determinations must be preceded by the opportunity for the affected patient to obtain an evidentiary hearing, both under state action principles and the Fourteenth Amendment's Due Process Clause and under applicable federal and state "fair hearing" regulations. (A. 157, 166, 167). Petitioners stipulated to their current policy of refusing to provide hearings for Medicaid patients subjected to these discharges or transfers.[5] Peti-

---

[4] Similarly, petitioner State Commissioner of Social Services Barbara Blum stated in a letter to the Regional Medicaid Director at the Department of Health and Human Services (undated, at page 2) that "New York State has determined that an involuntary Utilization Review transfer which requires a physical move out of a facility is medically contra-indicated." Defendants' Second Supplement to Joint Appendix in Court of Appeals, received 10/16/81.

[5] Petitioners' assertion (Brief, page 14) that a patient subjected to a facility-initiated discharge or transfer could request and obtain a URC determination and State hearing, although "not entitled" to either, is misleading. Petitioners stipulated in the Joint Pre-Trial Order that these patients

tioners further stipulated that during an earlier period they had conducted 10 hearings (with 5 reversals on the merits) of URC determinations to transfer patients to a higher level of care (A. 181), and that a number of the URC transfer decisions obtained by respondents in discovery were to a higher level of care (with 60 percent of them reversed on the merits after hearing). (A. 199, 205). Respondents alleged that a "substantial proportion" of facility-initiated transfers and URC transfers to a higher level of care "are not proper under applicable federal and state regulatory prohibitions against arbitrary discharge" (A-182) and "are used by facilities to rid themselves of patients they do not wish to retain" (A. 189). Finally, petitioners stipulated to, and the District Court certified, the expansion of the class definition to include "all residents of skilled nursing and health related facilities in New York State who are recipients of

---

"do not have a right to prior notice and hearing" "although the patient may request that the decision be reviewed by the URC and, *upon such review*, are entitled to the procedural rights [of a hearing]." (emphasis added). (A. 181-82). Respondents' and petitioners' attorneys understood that language to mean what it says, namely, that URC review in these cases was not a matter of right and was not guaranteed. Affected patients were given no notice of even the right to request such URC review, and petitioners further stated that their policy of gratuitously honoring such requests, to the extent they were honored, was under review and "may stop." (A. 182). In his deposition, Anthony Maddaloni, Health Program Administrator in the Bureau of Long-Term Care Services of the State Department of Health, explained that a patient transfer directed by a private physician "doesn't go through the UR committee's functions." (A. 137). That statement is an admission of petitioners. (A. 208). Finally, a letter dated April 27, 1981 from Mr. Maddaloni to a nursing home administrator clarifies petitioners' policy by explaining that the URC is notified of a patient transfer occurring outside the URC review process only if, coincidentally, "the patient's [URC] continued stay review date corresponds with the [non-URC] physician's order." Copy of letter attached as Appendix B to "Plaintiffs' Brief in Opposition to Defendants' Petition for a Writ of Certiorari," dated June 17, 1981.

Medicaid benefits" (A. 151, 241-42), a class totalling about 95,000 persons. (A. 168).

The existence of class members who are actually threatened with such transfers was further confirmed by three letters from petitioners' agents which were provided to respondents' attorneys by petitioners' counsel and were attached as appendices to "Plaintiffs' Brief in Opposition to Defendants' Petition for a Writ of Certiorari," dated June 17, 1981. Two letters, dated December 18, 1980, are from Richard Ruid, Senior Social Services Program Specialist of the State Department of Social Services, identifying two respondent class members (Ewell Perry and Gilberta Kamen) recommended for transfer out of their nursing homes by their attending physicians and directing the local Department of Social Services to provide them with hearings in accordance with the District Court's Order in this case. The other letter, dated April 27, 1981, is from Anthony Maddaloni, Health Program Administrator in the Bureau of Long-Term Care Services of the State Department of Health, informing a nursing facility administrator that the patients whom the facility sought to discharge were entitled to agency hearings in this case.

Petitioners vigorously defended against respondents' facility discharge/transfer claims on the merits in both the District Court and the Court of Appeals. At no time in either of those courts did petitioners even suggest that these issues failed to present a justiciable controversy. The District Court ruled and the Court of Appeals affirmed that state action and the due process right to a prior evidentiary hearing attach to a facility's patient discharge or transfer to a lower or higher level of care, outside of the URC review process, and to a facility patient transfer to a higher level of care pursuant to an adverse URC determination. (A. 240, 241-43, 245-53). Only after losing twice on the merits of these issues did petitioners raise the justiciability question, for the first time, in this Court.

STATUTORY AND REGULATORY SCHEME

Nursing facilities in New York State are comprehensively regulated in minute detail by an elaborate matrix of federal and state statutes, regulations, and administrative directives. It is through this network of federal and state laws that the State is closely involved in the nursing facilities' relationship with their Medicaid patients, from the point of their admission through the time of their discharge or transfer. These laws also constitute the primary bases for the finding the state action and statutory hearing rights in a nursing facility's involuntary discharge or transfer (to a lower or higher level of care) of a Medicaid patient. For the convenience of the Court, this statutory and regulatory scheme is presented here, as it bears upon the State's control over the facility's admission and discharge/transfer of Medicaid patients,[6] the State's identification of patients to be moved by the facility, the penalties for the facility's failure to move inappropriately placed patients, the State's responsibility to provide SNF/ICF care for Medicaid patients in the facilities of their choice, the State's responsibility for the correctness of the facility's action in discharging or transferring a Medicaid patient, the State's subsidizing of nursing facilities, and the Medicaid patient's federal and state law right to a hearing when discharged or transferred by a facility.

A. State's Control Over Facility Admission And Discharge/ Transfer Of Medicaid Patients

An SNF or an ICF can admit and retain a Medicaid patient only on a physician's certification and periodic medical recertification of the patient's need for SNF or ICF services. Social Security Act, 42 U.S.C. §§ 1396b(g)(1) (A) and (B),

---

[6] The nursing facility conduct that is governed by these federal and state laws is wholly independent of the review functions performed by URCs, which, except for URC determinations to transfer patients to a higher level of care, are not at issue in this Court.

1395x(j)(12); 42 C.F.R. §§ 442.306, 456.260(a) and (b), 456.270(a), 456.360(a) and (b), 456.370(a); 10 N.Y.C.R.R.[7] §§ 415.1(b), 730.2(b). The patient's appropriateness for admission to an SNF or ICF must be determined by the physician's application of the patient assessment criteria and the New York State Long Term Care Placement Form, called the DMS-1, devised and prescribed by the State Department of Health.[8] 10 N.Y.C.R.R. §§ 415.1(a), 420.1(b), 730.2(a), 740.2(b). The patient care plan which the SNF or ICF is required to develop promptly after the admission of the patient must contain a discharge plan that details the plans and steps for discharging or transferring the patient when he is determined to no longer require placement in that facility. 42 C.F.R. §§ 456.280, 456.371, 456.380; U.S. Department of Health and Human Services ("HHS") (Social and Rehabilitation Service) Medical Assistance Manual, § 5-60-20, pages 6, 9, 10, 45; 10 N.Y.C.R.R. §§ 416.1(K)(2)(ii), 421.3(b)(2), 731.1(K)(2)(ii), 740.6(p), 741.3(b)(2).

Each SNF or ICF is required to promptly discharge or transfer to a lower or higher level of care, without provision for a hearing, any Medicaid patient who is determined by the facility director, a facility staff physician, or the patient's attending physician to be inappropriately placed there because SNF or ICF care is no longer medically necessary or medically sufficient for the patient, the patient's behavior is dangerous or

---

[7] Volume 10 of the New York Code of Rules and Regulations contains the official regulations of the New York State Department of Health.

[8] The DMS-1 form is "scored" by the assignment of points to patient conditions (such as "impaired judgment," "toileting," "wanders") according to the numerical scoring system promulgated by the Department of Health. The points for each patient are totalled to determine a "predictor score." The predictor score cut-off for an SNF is 180 points and above; the cut-off score for an ICF is 60 points and above. Patients failing to achieve the minimum score are determined to be inappropriately placed in their facilities. (A. 170).

unacceptable or disturbing to others, the patient is suffering from drug or alcohol addiction, or the patient suffers from a communicable disease. 42 C.F.R. § 442.307; HHS Medical Assistance Manual, § 5-60-20, page 45; 10 N.Y.C.R.R. §§ 415.1(b) and (i), 416.9(d), 420.1(a) and (i), 421.13(d), 704.1(b)(2), 730.2(b) and (i), 731.11(d), 740.2(a) and (i), 741.13(a)(3), 741.14(d); 18 N.Y.C.R.R.[9] § 505.20; New York State Department of Health: Hospital Memorandum 77-74 (8/17/77) (page 4), Health Facilities Memorandum 79-47 (8/27/79) (page 1 of "Questions and Answers").[10] Although a patient's refusal to move to a higher level of care pursuant to a URC determination does not result in the termination of the patient's Medicaid benefits, the facility is directed to arrange the move "as soon as possible." New York State Department of Social Services Administrative Directive[11] 78 ADM 31 (6/28/78) (Addendum #1, page 1). In determining whether a Medicaid patient is no longer appropriately placed in an SNF or ICF and should be discharged or transferred to a lower or higher level of care,[12] the SNF and ICF are mandated to utilize the detailed patient assessment standards and the DMS-1 long term care placement form devised and prescribed by the State Department of Health. 10 N.Y.C.R.R. §§ 416.9(d)(4), 421.13(d)(4), 731.11(d)(4), 741.14(d)(4); 18 N.Y.C.R.R.

---

[9] Volume 18 of the New York Code of Rules and Regulations contains the official regulations of the New York State Department of Social Services.

[10] The New York State Department of Health issues formal and legally binding directives to SNFs and ICFs through its Hospital Memorandums and Health Facilities Memorandums.

[11] The New York State Department of Social Services issues formal and legally binding directives to local social services districts through its Administrative Directives.

[12] As indicated earlier, these facility review responsibilities are independent of the continued stay review functions of URCs, which are described at 42 U.S.C. §§ 1396b(g)(1)(c), 1395x(K); 42 C.F.R. §§ 405.1137, 456.400.

§ 505.20(b)(4); New York State Department of Health: Hospital Memorandums 77-9 (1/31/77), 77-10 (2/9/77), 77-13 (2/11/77). In order to facilitate the transfer of patients, the SNF or ICF that is to receive the patient is directed to accept him based on the transferring facility's completion of the DMS-1 form. Hospital Memorandums 77-60 (7/5/77) (page 2), 77-74 (page 1).

B. State's Identification Of Patients To Be Moved By The Facility

The State Department of Health is required to send medical review teams to conduct annual on-site inspections of all SNFs and ICFs (called Periodic Medical Reviews, or PMRs, for SNFs, and Independent Professional Reviews, or IPRs, for ICFs), during which individual medical reviews are performed on each SNF and ICF patient specifically to assess the appropriateness of his continued placement in the facility. 42 U.S.C. §§ 1396a(a)(26), 1396a(a)(31), 1396b(g)(1)(D); 42 C.F.R. § 456.600 *et seq*. In its report to the Department of Health, the medical review team identifies particular patients whose continued placement in their SNF or ICF facilities is determined to be inappropriate and recommends their discharge or their transfer to a lower or higher level of care. 42 C.F.R. § 456.611; HHS Medical Assistance Manual, § 5-60-20, pages 2, 19, 23-24, 26. A copy of that report is sent to facilities with inappropriately placed patients and the facilities are expected to comply with the State medical team's recommendations to relocate identified patients. 42 C.F.R. § 456.612; HHS Medical Assistance Manual, § 5-60-20, page 29; Health Facilities Memorandum 80-54 (5/16/80) (page 2).

C. Government-Created And State-Enforced Penalties For Facility's Failure To Discharge Or Transfer Patients

SNFs and ICFs that fail to move patients considered to be inappropriately placed are subject to the imposition of substantial penalties in the form of fines, non-reimbursement for services rendered, and suspension from participation in the Medi-

caid program. 42 U.S.C. § 1396h; 42 C.F.R. §§ 420.100 *et seq.*, 431.54(f) (adopted October 1, 1981); HHS Medical Assistance Manual, § 60-90-20, pages 3-6; New York Social Services Law § 367(2); New York Public Health Law §§ 2803(6) and (7), 2897 *et seq.*; 18 N.Y.C.R.R. §§ 505.9(u), 505.20(b)(2) and (5), 515.2, 515.3, 516.1, 540.8(g); 10 N.Y.C.R.R. § 414.18, Part 742.

D. State's Responsibility To Ensure Continuing Provision Of Appropriate SNF or ICF Services For All Eligible Medicaid Recipients In Facilities Of Their Choice

The *State* is obligated to provide SNF services and (since it has undertaken to make them available) ICF services to all Medicaid recipients over 21 years of age, an obligation it discharges through nursing facilities. 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a)(4)(A) and (5), 1396d(a)(15); 42 C.F.R. § 405.1133. The *State* is obligated to ensure the provision of these SNF and ICF services equally in amount, duration, and scope for all eligible Medicaid recipients age 21 or older, subject only to the *State's* right to limit services based on medical necessity and appropriateness. 42 U.S.C. § 1396a(a)(10)(B)(i); 42 C.F.R. §§ 440.210, 440.230(c)(2), 440.240, 440.250(a).

The *State* is required to secure the right of all eligible Medicaid recipients to continue to obtain assistance from the SNFs or ICFs they have chosen, once those facilities have undertaken to admit them. 42 U.S.C. § 1396a(a)(23). The State is also responsible for securing the rights of SNF and ICF patients to be free of involuntary discharge or transfer to a lower or higher level of care by their facilities except for valid medical reasons or for their welfare or that of other patients and with due regard to their right to refuse treatment. 42 C.F.R. §§ 442.1(a), 442.202(c), 405.1121(K)(4), 442.311(b)(1)(iii), 442.311(c); New York Social Services Law §§ 364(2)(a) and (b), 364-a(2); New York Public Health Law §§ 2803-c(1), 2803-c(3)(e); 18

N.Y.C.R.R. § 360.29; 10 N.Y.C.R.R. §§ 414.14(4), 730.17(4), 740.14(4).

E. State's Responsibility For Correctness Of All Patient Discharges/Transfers And Of The Medicaid Decisions Based Thereon

1. Facility admission/discharge decisions

Officials of the New York State Departments of Health and Social Services are responsible under federal and state law for the validity of *all* decisions to admit Medicaid recipients to and to discharge or transfer them from SNFs or ICFs, and that responsibility cannot be delegated to private entities. 42 C.F.R. §§ 431.10(e), 435.403, 435.930, 456.271, 456.372; HHS Medical Assistance Manual, § 5-60-20, page 46; New York Public Health Law § 2801(1), 2803(1)(d); New York Social Services Law §§ 367(1) and (2), 367-c(1); 10 N.Y.C.R.R. §§ 415.1(a), 731.11(f)(2) and (3), 741.14(f); 18 N.Y.C.R.R. §§ 505.9(b)(1) and (2), 540.1, 540.4, 540.5, 540.5(a)(5)(i); Hospital Memorandums 77-10 (page 5), 77-60 (pages 1, 2, 3), 77-74 (page 8). SNFs and ICFs are required to submit to the State Department of Health for its review and approval all completed DMS-1 forms upon which facilities base their discharge or transfer of patients. Hospital Memorandums 76-135 (12/16/76) (page 3), 77-35 (4/11/77), 77-60 (pages 2 and 4); Health Facilities Memorandum 79-23 (4/27/79) (pages 2, 4).

2. Medicaid decisions

Federal and state law also impose upon the State Department of Social Services the non-delegable duty to review for correctness all determinations, including facility discharges/transfers of Medicaid patients, upon which Medicaid eligibility or benefit adjustment decisions are based. 42 U.S.C. § 1396a(a)(5); 42 C.F.R. §§ 431.10(c) and (e), 431.11(d), 435.916(c); New York Social Services Law §§ 65(5)(b) and (d), 366-a(5) and

(6); 18 N.Y.C.R.R. §§ 351.21(f)(6) and (7), 351.22(d), 351.22(e), 351.22(e)(2); 358.9(a) and (b).

F. State's Subsidizing Of Nursing Facilities

The State must make reasonable and adequate reimbursement payments to SNFs and ICFs for services rendered to Medicaid patients, including all items of expense incurred by facilities in meeting federal definitions and standards and in complying with state health standards and licensing requirements. 42 U.S.C. § 1396a(a)(13)(A); 42 C.F.R. §§ 447.279, 447.302, 447.303. New York State supplies more than 90 percent of the patients in SNFs and ICFs (A. 169) and subsidizes both the operating costs and capital expenditures of those facilities. Allowable costs that are fully reimbursed by the State include all items of provider expense that are attributable to patient care, including all regular room, dietary and nursing services; the cost of physician and surgical supplies; the use of equipment and facilities; all items furnished routinely to patients such as patient gowns, water pitchers, basins, and bedpans; items distributed or used individually in small quantities such as cotton balls, bandaids, aspirin, and tongue depressors; items used by individual patients such as ice bags, crutches, and wheelchairs; laundry services; drugs; salaries; housekeeping and maintenance services; and social work and leisure activities. 42 C.F.R. §§ 447.281, 447.331. *See Public Reimbursement of Nursing Homes — A Technical Guide for Resident Advocates,* Patricia A. Butler (Research Institute on Legal Assistance, Legal Services Corporation, 1980) (hereinafter "Butler"), pages 83-4; *Bruce Spitz, Medicaid Nursing Home Reimbursement in New York* (The Urban Institute Press, 1980) (hereinafter "Spitz"), page 64. Rates are set prospectively and are adjusted upward for inflation and for newly enacted laws affecting costs. Spitz, page 64; Butler, pages 56-7 and Chart A.

The State fully reimburses the facility owner for the costs of his capital assets including the interest on mortgage payments, maintenance expense, taxes and depreciation on his real estate, and the depreciation on his buildings and fixed equipment. Further, where the owner of a proprietary facility invests capital in purchasing land, buildings, and equipment, the State reimburses him for the "cost" of that investment by guaranteeing him a return on his investment. As authorized by federal law, New York State provides the facility owner with a return on net invested equity at the Medicare rate, which was about 13.5 percent in 1979 and about 15 percent in 1980. Spitz, pages 7, 10, 43, 81, 82; Butler, pages 22, 24, 25, 31, 56-7, 65, 72, 77, 80.

The State pays a profit on a proprietary provider's investment at a market-related price in order to attract and maintain private investment in nursing homes. Voluntary or non-profit facilities can also realize efficiency profits by keeping their actual operating costs below the reimbursement ceilings set by the State. 43 Fed. Reg. 4861 (2/6/78). The New York State reimbursement system provides additional profits to non-profit facilities by allowing them to keep the difference between their actual costs and the prospective rate and by awarding facilities with high quality ratings more than 100 percent of their average group rate. Spitz, page 64; Butler, pages 56-7 and Chart A. Non-profit facilities are further subsidized by exemption from income, property, and sales taxes and have access to capital funding through government loan and grant programs. New York State provides facilities with construction funds through the State Housing Finance Company. Public Health Law Article 28A. Finally, additional profit inheres in the fact that capital costs for proprietary facilities — including interest, maintenance, taxes, and depreciation on land, plant, and fixed equipment — are not only fully reimbursed by the State but tax deductible as well. Thus much of the cash income generated by Medicaid is shel-

tered from taxation. Spitz, pages 10-11; Butler, pages 20, 25, 26, 27, 44, 54, 62, 72, 91.

G. Federal And State Law Provisions Entitling Discharged Or Transferred Medicaid Patients To State Hearings When State Terminates Or Reduces Medicaid Benefits

Applicable federal and state law provisions entitle a Medicaid recipient to notice and a state agency "fair hearing" whenever the agency takes "action" to reduce or terminate Medicaid eligibility or covered services, including when that agency "action" is based on a nursing facility's discharge or transfer of a Medicaid patient. 42 C.F.R. §§ 431.200, 431.201, 431.213(f) (agency hearing when "a change in the level of medical care is prescribed by the recipient's physician"), 431.220, 435.919; HHS Medical Assistance Manual, § 5-100-20, page 2 ("[a] recipient who believes that his free choice of provider has been denied or impaired has the right to request a fair hearing before the State agency"); New York Social Services Law §§ 22(1) and (3) and (5), 22(5)(c) and (d); 18 N.Y.C.R.R. §§ 351.23(a) and (b), 355.3(a)(2) and (b)(1), 358.3, 358.4(a), 358.5(a), 358.8(a)(1), 358.8(d)(1)(iv), 358.8(d)(1)(viii),[13] 360.18(a)(1); 10 N.Y.C.R.R. § 730.17(c).

SUMMARY OF ARGUMENT

This case clearly presents a justiciable controversy since the named respondents and intervenor-respondents ("respondents") were threatened with the injury of arbitrary and summary discharge or transfer by the nursing facilities in which they reside. As alleged in respondents' complaints, the injury of involuntary discharge or transfer from their nursing facilities was initially threatened by the facilities' implementation of erroneous adverse URC determinations that respondents were

---

[13] Proposed to be withdrawn, by State Department of Social Services notice dated December 29, 1981.

inappropriately placed and should be moved. With the petitioners' agreement in this case to forbid the implementation of all URC determinations to discharge Medicaid patients or transfer them to a lower level of care, respondents became subject to the distinct threat that the facilities would arbitrarily move them on their own initiative. The threat was concrete, since these now unenforceable determinations had been rendered by the facilities' own URC physicians and affirmed by the State, the URC determinations were based on completion of the State-prescribed DMS-1 long-term care assessment form, and the State by law required the facilities themselves to initiate the discharge or transfer of all inappropriately placed patients on the basis of a completed DMS-1 form without provision for a hearing. On these facts and circumstances, respondents were threatened with injury from facility-initiated discharges or transfers and therefore had, and continue to have, a "personal stake" in the controversy concerning whether state action and the due process right to a hearing attach to facility discharges or transfers of Medicaid patients sufficient to give them standing to sue. *United States Parole Comm'n* v. *Geraghty*, 445 U.S. 388 (1981); *Gladstone, Realtors* v. *Village of Bellwood*, 441 U.S. 91 (1979); *Truax* v. *Raich*, 239 U.S. 33 (1915).

Furthermore, petitioners expressly stipulated in this case to the assertion and adjudication of respondents' claims challenging summary facility discharges/transfers, and to the amendment of the class definition to encompass those claims. Petitioners strenuously contested those claims on the merits in both the District Court and the Court of Appeals and raised the justiciability issue for the first time in this Court.

Under the principles set forth in this Court's state action decisions, state action, and hence the hearing requirements of the Fourteenth Amendment's Due Process Clause, clearly attach to a nursing facility's discharge of a Medicaid patient or his transfer to a lower or higher level of care, outside of the

URC review process, and to his transfer to a higher level of care pursuant to a URC determination. State action flows, first, from the nexus between the State and the private conduct which is created by the State's close and comprehensive control by law over the facility's discharge or transfer of a Medicaid patient. The State requires that an SNF or ICF must evaluate, independent of URC review, every patient's continuing need to stay in the facility, using the State's standards and the State's DMS-1 assessment instrument. The State requires that the facility promptly discharge or transfer, without a hearing, all patients thus identified as inappropriately placed and then adjusts the Medicaid benefits of the Medicaid patients moved in this manner by the facility. The State also sends medical review teams to each SNF and ICF to identify patients whom the facility is expected to move. Finally, the State directs the receiving facility to accept the transferred patient based on the DMS-1 form as completed by the transferring facility. Failure of the facility to move inappropriately placed patients subjects it to State-prescribed and State-enforced penalties. The State's commanding and sanctioning of the nursing facility's discharge or transfer of a Medicaid patient plainly creates state action here and supplies the critical factor lacking in the cases in which this Court has found no state action in challenged private conduct. *Polk County* v. *Dodson*, 50 U.S.L.W. 4077 (December 14, 1981); *Flagg Brothers, Inc.*, v. *Brooks*, 436 U.S. 149 (1978); *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974); *Moose Lodge No. 107* v. *Irvis*, 407 U.S. 163 (1972).

There are present as well a number of additional forms of state approval of and responsibility for the facility's discharge or transfer of Medicaid patients. The State is legally obligated to provide appropriate SNF or ICF services for all eligible Medicaid recipients in the facility of their choice. Further, the State is legally obligated to approve or disapprove on the merits every facility discharge or transfer of a Medicaid patient when it

occurs and, as well, when the State adjusts the patient's Medicaid eligibility.

State action also inheres in the symbiotic relationship between the State and the facilities which makes the State a joint participant in the facilities' discharge or transfer of Medicaid patients. *Burton* v. *Wilmington Parking Authority*, 365 U.S. 715 (1961). The State reimburses the facility for practically all of its operating and capital costs, guarantees it a profit, and provides more than 90 percent of its patients. The facilities, on the other hand, satisfy the State's legal obligation and public function of providing SNF and ICF services for all eligible Medicaid recipients.

Finally, applicable statutory and regulatory provisions of federal and state law independently require the State to provide a hearing for any Medicaid recipient whose Medicaid benefits are reduced or terminated on the basis of his discharge or transfer by a nursing facility.

ARGUMENT

POINT I

The Case Presents A Justiciable Controversy

This case presents a justiciable controversy since the respondents satisfy the minimum "personal stake" requirement of Article III of the Constitution that they "personally . . . suffered some actual or threatened injury as a result of the putatively illegal conduct of the defendant." *Gladstone, Realtors* v. *Village of Bellwood*, 441 U.S. 91, 99 (1979); *United States Parole Comm'n* v. *Geraghty*, 445 U.S. 388, 396 (1981). As explained in the "Statement of the Case," page 1, the named respondents (including the original two named respondents, the named organizational respondent The Gray Panthers on behalf of its members, and the ten intervenor-respondents) all alleged in their complaints injury from wrongful discharge or transfer by their nursing homes, then originating from adverse URC

determinations and State fair hearing decisions.[14] Later, temporary restraining orders, a preliminary injunction, and a partial consent judgment were obtained that halted, first temporarily and then permanently, the implementation of all of these adverse URC determinations.[15] However, the threatened injury of the respondent's wrongful discharge or transfer by their nursing homes continued to exist, because of the likelihood that the facilities themselves, instead of the URCs, would initiate the patient moves without adequate procedural safeguards.[16]

The immediacy of this threat of respondents' summary relocation at the initiative of their facilities was self-evident. URC physicians in the facilities had determined that the respondents were inappropriately placed there and should be moved, and those determinations had been affirmed by the State Department of Social Services.[17] Those determinations were based on

---

[14] It is the nursing facility that actually discharges or transfers the patient, whether the patient move be prompted by a decision of the URC, the attending physician, the facility staff physician, or the facility operator or medical director. See mailgram from facility administrator, introduced into evidence at preliminary injunction hearing, threatening to immediately transfer several named respondents following adverse URC determinations. (A. 96-7).

[15] Since it was the nursing facility's actual relocation of the patient that constituted the injury that respondents sought to prevent, the temporary restraining orders and preliminary injunction included prohibitions against discharge or transfer of the respondents and class members by the proprietors and administrators of their nursing homes. (A. 41-2, 100-101, 116).

[16] Respondent Gray Panthers derived its standing to sue from allegations in the first amended complaint that some of its 5,000 members were injured by involuntary transfers or threats of such transfers. (A. 21). *Cf. United States* v. *SCRAP*, 412 U.S. 669, 688 (1973).

[17] Moreover, the attending physicians of respondents Foley, Ashkenazy, Birenzweig, Zahl, and Kolman had declined to exercise their right under law to initially object to the adverse URC determinations. See DMS-1s attached to respondents' affidavits in support of applications for temporary restraining orders. Record on appeal docket numbers (hereinafter "R.A. Doc. No.") 12, 15.

the completion of the State-prescribed DMS-1 long-term care assessment form, using the State's standards. The facilities were under a State-imposed mandate to evaluate all patients, using that same DMS-1 instrument, and to promptly discharge or transfer, without a hearing, patients identified as inappropriately placed. Failure of the facilities to move respondents might subject them to substantial penalties under law, including fines, non-reimbursement for services rendered, and suspension from the Medicaid program. See "Statutory and Regulatory Scheme" (hereinafter "Statutes"), pages 7-11.

Under these circumstances, it was apparent that the URC determinations and facility-initiated actions to move the respondents were virtually interchangeable,[18] and that there existed a distinct and palpable threat that the respondents' facilities would in effect convert these unenforceable erroneous URC determinations into their own decisions to discharge or transfer the respondents without a hearing, *Cf. Traux* v. *Raich*, 239 U.S. 33, 38-9 (1915) (alien employee has standing to challenge constitutionality of Arizona statute which imposed penalties upon companies employing more than 20 percent aliens). Finally, petitioners' agents have identified in writing particular class members who would have been summarily transferred by their facilities in the absence of the injunction in this case prohibiting such transfers without a hearing. See "Statement of Case," page 6.

Furthermore, petitioners expressly stipulated in this case to the addition to this suit of respondents' claims that facility discharges or transfers are state action and must be accompanied by the opportunity for a hearing. Petitioners acknowledged that involuntary patient relocations are always a threat to the patient's health. They stipulated to their policy of failing to

[18] The doctors were interchangeable as well, since attending physicians in a facility are often URC physicians for other patients in the same facility. (A. 173); Maddaloni Deposition, pages 66-7. (R.A. Doc. No. 98).

ensure hearings in cases of facility discharges or transfers to a lower level of care or URC determinations that a patient should be transferred to a higher level of care, and they agreed to an expanded definition of the class. They stipulated to respondents' assertion of claims challenging the validity of these discharges or transfers without the patient's right to a hearing [19] and expressly agreed to the District Court's adjudication of these claims. See "Statement of the Case," pages 4-6. Petitioners vigorously contested these claims on the merits, with no suggestion of any justiciability problem, in both the District Court and the Court of Appeals, and the issues come to this Court sharply presented by "self-interested parties advocating opposing positions." *United States Parole Comm'n, supra,* 445 U.S. at 403.

Under the facts and circumstances of this case, respondents submit that both the Article III limitations and the prudential aspects of the case and controversy requirement are satisfied here and that this Court should decide the merits of the issues presented.

POINT II

State Action Attaches To A Nursing Facility's Discharge Or Transfer Of A Medicaid Patient

It is important at the outset to dispel the serious misimpression fostered by petitioners in their Brief to this Court that the issue in this case is whether a doctor's medical decision to alter the treatment of his Medicaid patient is state action. That suggestion is fundamentally in error. From the beginning of this lawsuit the respondents' challenge has been to the involuntary discharge or transfer of Medicaid patients from and by their nursing facilities without adequate safeguards, initially as a

---

[19] Respondents further alleged that these patient transfers were erroneous under law and were used by facilities to rid themselves of undesirable patients. (A. 182, 189).

consequence of adverse URC determinations. (A. 19, 22, 33, 48, 56, 74-5). Later, by stipulation between the parties, the respondents' challenge was to the nursing facility's summary discharge of patients or their transfer to a lower or higher level of care, independent of URC review, and to a higher level of care pursuant to a URC determination. (A. 157, 166-7, 234-5). Thus, the claim before this Court is whether state action attaches to a *nursing facility's summary discharge or transfer of the patient*, whether that facility action springs from the medical decision of a facility staff physician, the patient's attending physician, the facility medical director, or (in some transfers to a higher level of care) a URC determination, or from a purely non-medical decision of the facility operator that the patient is troublesome, antisocial, disturbed, or just plain undesirable. [20] A physician's medical decision that does not culminate in the facility's involuntary discharge or transfer of the Medicaid patient is not, and never was, the subject of respondents' claims. [21]

Application of the principles of this Court's state action decisions to the circumstances of this case compels a finding of state action when a nursing facility discharges a Medicaid patient into the community or an Adult Home [22] or transfers a

[20] Accordingly, the District Court's partial final judgment enjoined the *nursing facility's* discharge or transfer of a Medicaid patient without the opportunity for a state hearing. (A. 242-3).

[21] Thus, contrary to petitioners' suggestion (Brief, pages 37-8), respondents do not claim state action in a physician's decision to change his patient's drug prescription or to continue or withdraw the patient's chemotherapy treatment. On the other hand, respondents argue that state action attaches to *all* involuntary out-of-facility transfers by nursing facilities, including the unusual transfers highlighted by petitioners in their Brief (pages 38-9).

[22] Adult Residential Care Facilities, or Adult Homes, are not medical facilities, are not permitted to provide medical or nursing services, sometimes mix elderly patients with ex-mental patients and alcoholics, and are not equipped to handle a wide range of patient impairments and needs. (A.

patient to a lower or higher level of care, outside of the URC review process, and when a facility transfers a patient to a higher level of care pursuant to a URC determination. The state action finding flows ineluctably, first, from the direct nexus between the State and the private conduct created by the State's direct control and direction over the facility discharge/transfer action and, second, from the unique mutual interdependence between the State and the nursing facility and the public function served by the facility in caring for Medicaid patients. [23]

A. Nexus between State and nursing facility conduct

The crucial factor that is present in this case, and was notably absent from the cases in which this Court found no state action

---

176-7); deposition of Elizabeth Dinehart, Regional Director of the Division of Adult Residential Care of the State Department of Social Services, pages 13, 16-20, 23-28. Ms. Dinehart's deposition statements are admissions of the petitioners. (A. 208). (R.A. Doc. No. 95).

[23] The consequence of the finding of state action here is only to trigger the requirement of the Fourteenth Amendment's Due Process Clause that Medicaid patients have the right to obtain a state agency hearing before the facility can discharge or transfer the patient. At the hearing the issue under federal and state law will be whether or not the facility is properly discharging or transferring the patient for valid medical reasons, for the welfare of the affected patient or other patients, or for non-payment for his stay (42 C.F.R. §§ 442.202(c), 405.1121(k)(4), 442.311(c); 10 N.Y.C.R.R. §§ 414.14(4), 730.17(4), 740.14(4)), and consistent with the patient's "right to refuse treatment" (42 C.F.R. § 442.311(b)(1)(iii); Public Health Law § 2803-c(3)(e); 10 N.Y.C.R.R. § 740.14(4)) and to be free of discharge solely because of his Medicaid status (10 N.Y.C.R.R. §§ 730.2(1), 740.2(k)). The validity of the purported medical reasons for the patient move will be measured against the very detailed standards for necessary skilled nursing or intermediate care facility services set forth in federal and state regulations. 42 C.F.R. §§ 440.40(a), 405.127-128a; federal Medical Assistance Manual, § 5-60-20 (pages 33-46); State Department of Health: Hospital Memorandums 77-9 (1/31/77), 77-10 (2/9/77) and 77-13 (2/11/77).

in challenged private conduct,[24] is the State's affirmative command that the nursing facility perform the very conduct in question — the summary discharge or the transfer to a lower or higher level of care of a Medicaid patient who is thought to be inappropriately placed in that facility. That affirmative command takes the form of the requirement under federal and state law that the facility first identify, using State standards and the State-created DMS-1 long-term care assessment instrument, patients whose continued stay is medically or socially inappropriate, and then promptly discharge those patients or transfer them to an appropriate facility without a hearing. See "Statutes," pages 7-10. The State Department of Social Services then terminates, reduces or increases the Medicaid patient's benefits on the basis of that facility action. (A. 169).

Pursuant to federal and state law, the State also sends medical review teams annually to every SNF and ICF to determine each patient's need for continued stay, notifies the facility of identified patients who should be moved, and directs the facility to discharge or transfer those patients. See "Statutes," page 10; deposition of Anthony Maddaloni, page 44 and A. 135-6, 143-5; Joint Pre-Trial Order (A. 193-4). The State command that an ICF move an inappropriately placed patient to an SNF is further reinforced when the URC determines that the patient should be transferred to the higher level of care. See "Statutes," page 9. The State solidifies its control over the facility transfer action by directing that the nursing facility which is to receive the transferred patient should accept that patient based on the

---

[24] *Polk County* v. *Dodson*, 50 U.S.L.W. 4077 (December 14, 1981) (public defender's representation of his client); *Flagg Brothers Inc.* v. *Brooks*, 436 U.S. 149 (1978) (warehouseman's sale of stored property); *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974) (public utility's summary termination of customer's electric service for non-payment); *Moose Lodge No. 107* v. *Irvis*, 407 U.S. 163 (1972) (private club's exclusion of Blacks).

proper completion of the State DMS-1 form by the transferring facility. See "Statutes," page 13. The facility's failure to discharge or transfer an inappropriately placed patient subjects that facility to State-prescribed and State-enforced penalties, including fines, non-reimbursement for services rendered, and suspension from participation in the Medicaid program. See "Statutes," page 10.

Under the decisions of this Court it is beyond cavil that the nexus created between the State and the private conduct by this State requirement, sanctioning, and enforcement of the private conduct in question is state action under the Fourteenth Amendment. *Moose Lodge No. 107* v. *Irvis*, 407 U.S. 163, 172 (1972) ("Our cases make clear that the impetus for the forbidden discrimination need not originate with the State if it is state action that enforces privately originated discrimination.") Thus in *Moose Lodge* this Court readily found state action in the regulation of the Pennsylvania Liquor Control Board that, though "neutral in its terms," required a private club to adhere to its racially discriminatory membership rules. *Id.*, at 177-9. *Contrast Polk County* v. *Dodson*, 50 U.S.L.W. 4077 (December 14, 1981) (State imposes no command or control over the public defender's representation of his client); *Flagg Brothers, Inc.* v. *Brooks*, 436 U.S. 149, 166 (1978) ("[T]he State of New York has not compelled the sale of a bailor's goods, but has merely announced the circumstances under which its courts will not interfere with a private sale."); *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345, 357 (1974) (The Pennsylvania Public Service Commission "has not put its own weight on the side of the proposed practice by ordering it. . . . [a]t most the Commission's failure to overturn this practice amounted to no more than a determination that a Pennsylvania utility was authorized to employ such a practice if it so desired.")

The state action finding in this case is confirmed by the presence of additional forms of the State's responsibility for, and its encouragement and approval of, the facility's discharge or transfer to a lower or higher level of care of Medicaid patients who are viewed as undesirable or inappropriately placed. The State Department of Health is legally obligated to evaluate and to approve or disapprove on the merits the facility's decision to discharge or transfer the patient, including the completed DMS-1 form on which the facility action is based. [25] See "Statutes," page 12. Federal and State law also require the State Department of Social Services to review and approve on the merits the facility discharge/transfer decision which is the basis for the Department's adjustment of the patient's Medicaid eligibility. See "Statutes," page 12. *Cf. Public Utilities Comm'n* v. *Pollack,* 343 U.S. 451 (1952) (state action found in regulatory agency's affirmative approval of the challenged practice of the local transit system).

The action of the State Department of Social Services in adjusting the patient's Medicaid benefits on the basis of the facility's discharge or transfer of the patient supplies overt official involvement in and additional impetus for the facility's action. [26] *O'Bannon* v. *Town Court Nursing Center,* 447 U.S.

---

[25] David B. Davidoff, Assistant Director of the Facility Surveillance Group in the Department of Health, in his affidavit of December 30, 1977 in this case confirmed (at paragraph 14) that "all DMS-1 forms completed by skilled nursing homes and intermediate care facilities" must be filed with the Department of Health, which "reviews DMS-1 forms to assure that they are properly completed." Plaintiffs' Exhibit 10, preliminary injunction hearing (1/4-1/5/78). Respondents' comprehensive study and analysis of more than 1500 DMS-1s completed by URCs showed a shockingly high rate of error in assessing patients' needs for their current level of care. (A. 199-204).

[26] See deposition of Richard Ruid, Senior Social Services Program Analyst in the Division of Medical Assistance of the State Department of Social Services, pages 55, 56 (A. 208); telegram of nursing home administrator threatening to transfer named respondents unless State continued Medicaid payments. (A. 96).

773, 786-7 (1980) ("The Government cannot withdraw these direct [Medicaid financial] benefits without giving the patients notice and an opportunity for a hearing on the issue of their eligibility for benefits."); *North Georgia Finishing, Inc.* v. *Di-Chem, Inc.*, 419 U.S. 601 (1975); *Fuentes* v. *Shevin*, 407 U.S. 67 (1972); *Sniadach* v. *Family Finance Corp.*, 395 U.S. 337 (1969) (state action in court clerks' participation in private enforcement of creditor pre-judgment remedies). *Contrast Flagg Brothers, supra*, 436 U.S. at 157 (noting the "total absence of overt official involvement" in the warehouseman's enforcement of his lien on stored property).

The State's legal obligations that attach when a nursing facility relocates a Medicaid patient include its responsibility to provide SNF and ICF services to all eligible Medicaid recipients, to assure each eligible patient his freedom to remain in a nursing facility which has accepted him, and to secure each nursing patient's right to be discharged or transferred only for specified cause. See "Statutes," pages 11-12. These obligations make it legally impossible for the State to remain neutral when a nursing facility involuntarily discharges or transfers a Medicaid patient. The State's asserted neutrality also cannot withstand petitioners' acknowledgment in this case that the trauma that accompanies any involuntary patient relocation is so unpredictable and so devastating that "the only way to protect the patient's health is to require that he consent to any proposed out-of-facility transfer."[27] (A. 220-21). See "Statement of Case," pages 3-4.

---

[27] David Glaser, Administrator of the Margaret Tietz Center for Nursing Care, observed in his deposition in this case (pages 47, 48) that a patient's move from a lower to a higher level of care can be even more traumatic than movement downward, "because they know, if they get moved from the HRF to the SNF, they might be dying, and, so, that's a very deep emotional problem for the patient . . ." (R.A. Doc. No. 101).

Petitioners have also admitted in this case that they turned down the recommendations of their own Task Force to eliminate the patient trauma of

Therefore, it is clear under this Court's decisions that state action lies here in the State's direct control over and responsibility for the nursing facility's discharge or transfer of a Medicaid patient.

B. Symbiotic relationship between state and nursing facility and facility's exercise of public functions.

A finding of state action is equally compelled in this case by the extent and nature of the mutually beneficial, or symbiotic, relationship between the State and the nursing facilities that makes the State a "joint participant" in the facility's summary discharge or transfer of a Medicaid patient. *Burton* v. *Wilmington Parking Authority*, 365 U.S. 715 (1961). In *Burton*, state action was based on the finding that the State was a "joint participant" in the racially discriminatory practices of a restaurant that was located in a publicly owned and financed parking facility and which "constituted a physically and financially integral and, indeed, indispensable part of the State's plan to operate its project as a self-sustaining unit," *Id.*, at 723-4. The degree of mutual interdependence between State and private entity is even more striking here — each is virtually indispensable to the other. The State subsidizes practically all the operating and capital costs of the facility (including the salaries of its employees and the costs of the land, building, and

---

out-of-facility transfers by encouraging the creation of more multi-level facilities containing both SNF and ICF levels of care. In his deposition in this case, Dr. Roger Herdman, Director of Public Health in the State Department of Health and a member of that Task Force, described the conclusions of the Task Force that involuntary patient transfers out of their facilities are "difficult, often inhuman and very often dangerous" and that the State should encourage the building of multi-level facilities. Deposition, pages 20, 21. But Dr. Herdman observed that although the State Legislature responded to the Task Force recommendations by giving the Commissioner of Health the authority to reclassify nursing homes to multi-level facilities, no such departmental action was taken. Deposition, pages 22, 23, 25. See A. 197-8, 208. (R.A. Doc. No. 100).

fixed equipment), supplies the facility with more than 90 percent of its patients (A. 169), and guarantees the owner a profit. See "Statutes," pages 13-15. The nursing facility literally depends upon the State for its very survival. Moreover, through its certificate of need and reimbursement policies the State rations the number and location of Medicaid nursing homes, creates and perpetuates a scarcity of nursing beds, and confers upon the facilities an artificial monopoly free of risks and competition in the provision of Medicaid nursing services.[28] *Contrast Jackson, supra,* 419 U.S. at 352 and n.8 (utility company's monopoly over provision of electric services was neither State-created nor free of competition); *Moose Lodge, supra,* 407 U.S. at 177 (private clubs lack monopoly over dispensing of liquor). Thus, the State "has elected to place its power, property and prestige" behind the actions of the facilities in summarily removing Medicaid patients.[29] *Burton, supra,* 365 at 725.

---

[28] *See Public Reimbursement of Nursing Homes — A Technical Guide for Resident Advocates,* Patricia A. Butler (Research Institute on Legal Assistance, Legal Services Corporation, 1980) (hereinafter "Butler"), pages 15, 18, 19, 37-8, 58, 66; Bruce Spitz, *Medicaid Nursing Home Reimbursement in New York* (The Urban Institute Press, 1980) (hereinafter "Spitz"), pages 48, 83. Petitioners have admitted that their halting of implementation of adverse URC determinations exacerbates the already serious shortage of nursing beds in the State (occupancy rate of 93 percent upstate and 91 percent downstate). (A. 135, 170, 191). This State-created and State-fostered scarcity of nursing beds significantly increases the incentives for facilities to discharge or transfer Medicaid patients and to replace them with more profitable private pay patients. Butler, pages 18, 19, 35, 38; Spitz, page 83; Comptroller General's Report to the Congress, "Entering a Nursing Home — Costly Implications for Medicaid and the Elderly" (November 26, 1979), page 103.

[29] Of course, transfer actions of the approximately 12 percent of the nursing facilities in New York State that are publicly owned and run are automatically state action. Spitz, page 19. *Memphis Light, Gas and Water Division* v. *Craft,* 436 U.S. 1 (1978).

On the other hand, the State depends implicitly upon the facilities to discharge the inherently governmental function, as set forth in the Social Security Act and the State Constitution and laws, of providing institutional nursing services for the State's indigent citizens. The State is made responsible under the Social Security Act and the New York State Constitution [30] for providing every eligible Medicaid recipient with needed SNF and ICF services. See "Statutes," pages 11-12. *Cf. Teitelbaum* v. *Sorenson*, Civ. No. 79-199 PHX WEC (D. Ariz, filed March 16, 1979) (state action in activities of private nursing home based in part on finding that Arizona law makes the duty to provide care for indigent persons a public function). *Contrast Jackson, supra*, 419 U.S. at 353 (Pennsylvania statutory and decisional law did not impose on the *State* the obligation to provide persons with electric service). [31] Further, just as the discriminatory practices in *Burton* allegedly improved its business and benefited the government agency financially (365 U.S. at 724), so do the facility transfers of allegedly inapprop-

---

[30] It is settled that under the New York State Constitution the provision of care — including institutionalized care — for old, infirm, and indigent adults who qualify for Medicaid benefits is inherently a public or governmental function. Article 17, §§ 1 and 3, of the New York Constitution. The New York Court of Appeals has made clear the fundamental governmental commitment represented by the constitutional provision at Article 17, § 1. Since the provision of assistance to the needy is "specifically mandated by our Constitution," it is "not a matter of legislative grace," but rather is a "fundamental part of the social contract" and imposes upon the State an "affirmative duty to aid the needy." *Tucker* v. *Toia*, 43 N.Y.2d 1, 7, 8 (1977). *Accord Matter of Lee* v. *Smith*, 43 N.Y.2d 453, 460 (1977).

[31] In performing the State's duty to care for needy persons, the nursing facility provides patients with food, clothing, shelter, and health care upon which they are totally dependent and which they cannot obtain elsewhere. *Cf. Marsh* v. *Alabama*, 326 U.S. 501 (1946); *Teitelbaum, supra* (nursing home is functional equivalent of a company town for the patients, since "all of their needs are met through services provided to them at the facility" and the "overwhelming percentage of the patients are not able to easily leave the facility; many are bedridden.").

riately placed patients benefit the State by satisfying its federally-mandated obligation, no longer dischargeable through the utilization review process, to move inappropriately placed patients. Finally, the State Department of Social Services is responsible for reviewing on the merits the correctness of the nursing facility's discharge or transfer of a Medicaid patient which is the basis for the Department's adjustment of the patient's Medicaid benefits. See "Statutes" page 12. As the Court of Appeals concluded in this case, to the extent that the State fails to perform that inherently governmental function, "[t]he State has, in essence, delegated a decision to increase or reduce a public assistance recipient's benefits to a 'private' party; but such a delegation cannot prevent due process guarantees from attaching." *Yaretsky* v. *Blum*, 629 F.2d 817, 820 (2 Cir. 1980).

In finding state action in the racially discriminatory practices of a private restaurant located in a public parking authority, this Court in *Burton, supra,* observed that "[i]t is irony amounting to grave injustice that in one part of a single building . . . all persons have equal rights, while in another portion, also serving the public, a Negro is a second-class citizen." 365 U.S. at 724. It is similarly "irony amounting to grave injustice" that when a nursing facility seeks to discharge or transfer a Medicaid patient on the basis of a URC physician's decision, the State requires a hearing and the patient's right to disapprove the move, but when that facility seeks to discharge or transfer the same patient based on the decision of the facility director, staff physician, or the attending physician, [32] the State mandates the prompt relocation of the patient without even a hearing. [33]

---

[32] In his deposition, Anthony Maddaloni acknowledged that "a physician who may be deriving a substantial part of his salary from treating patients in the facility may be the attending physician for 50 percent of facility and could nonetheless be a utilization review physician for the other patients." Deposition, p. 67. Also Joint Pre-Trial Order (A. 173).

[33] Although patient procedural safeguards are lacking, the potential for abuse and error is substantially greater in facility-initiated discharges or

As in *Burton*, the State and the private entity each constitutes an "integral and, indeed, indispensable" aspect of the other's requirements — the facility's need for patients and financial solvency and profit, and the State's need to fulfill its obligations under the Medicaid program and the New York State Constitution. Under these unique circumstances, the state action requirements of *Burton* are satisfied here. [34]

---

transfers than in URC moves. Federal regulations carefully minimize the risks that URC physicians will "do the bidding" of the facility whose patients they review by prohibiting those doctors from any financial interest in the facility or direct responsibility for the care of the patients reviewed. 42 C.F.R. §§ 405.1137(b)(3), 456.306(d). Facility or attending physicians or facility directors who initiate patient transfers outside of the utilization review process are not subject to these safeguards of objectivity and impartiality. Further the facility medical director or facility staff physicians, who are often the patient's attending physicians, have a loyalty to the facility which employs them and a duty to the State to relocate inappropriately placed patients.

[34] Patients who are discharged or transferred from their facilities without the opportunity for a hearing suffer not only the abrupt discontinuance of basic Medicaid services and benefits, but as well summary eviction from their homes, in a context in which the government heavily regulates and subsidizes the homes and narrowly circumscribes the permissible grounds for eviction. Under these circumstances, this case falls squarely within the rationale of Court of Appeals decisions that have found state action in the eviction of low-income tenants by private landlords of housing subsidized under sections 221(d)(3) or 236 of the National Housing Act. *Lopez* v. *Henry Phipps Plaza South, Inc.*, 498 F.2d 937 (2 Cir. 1974); *Joy* v. *Daniels*, 479 F.2d 1236 (1 Cir. 1973); *McQueen* v. *Drucker*, 438 F.2d 781 (1 Cir. 1973).

POINT III

A Medicaid Nursing Patient Has A Right Under Federal And State Law To A State Agency Hearing When The State Takes Action To Adjust His Benefit Level Based On A Facility's Patient Discharge Or Transfer To A Lower Level Of Care.

Federal and state statutes and regulations independently secure the right of a Medicaid patient in an SNF or ICF to notice and a state agency hearing whenever the agency takes "action" to terminate or reduce that person's Medicaid eligibility or benefits on the basis of the facility's discharge of the patient or his transfer to a lower level of care.[35] See "Statutes," page 15. These provisions thus provide non-constitutional grounds for deciding the respondents' rights to a State agency hearing in such cases.[36] *Cf. United States* v. *Rumely*, 345 U.S. 41, 45 (1953); *Crowell* v. *Bensen*, 285 U.S. 22, 62 (1932).

This Court's recent decision in *O'Bannon* v. *Town Court Nursing Center*, 447 U.S. 773 (1980), recognizes that it is the "action" of the State in withdrawing the direct financial benefits

---

[35] There is no analytical difference, for purposes of determining patient hearing rights under federal regulations, between the federal requirements of a State agency hearing when the facility transfer is based on a URC determination (to which petitioners unsuccessfully objected, Brief, pages 6 n.*, 34 n.*) and the requirement of such a hearing when the transfer is at the initiative of the facility. The 1976 letter from an Associate Regional Commissioner for Medical Services in Boston, upon which petitioners rely (Brief, page 6 n.*), states only that the statutory right to a hearing is triggered not by the URC or other recommendation to move the patient, but by the State agency's action in discontinuing or reducing Medicaid benefits on the basis of that recommendation.

[36] Respondents asserted and argued in both the District Court and the Court of Appeals the claims that federal and state law require State evidentiary hearings prior to the facility's patient discharge or transfer to a lower level of care. See Joint Pre-Trial Order (A. 157, 163, 166-7); Reply Memorandum in Support of Plaintiffs' Motion for Summary Judgment, R.A. Doc. No. 88, pages 4-8; Brief for Plaintiffs-Appellees in Court of Appeals, dated May 7, 1980, pages 19-21.

provided for Medicaid recipients in nursing homes that entitles the patient to a statutory fair hearing:

> The direct benefits are essentially financial in character; the Government pays for certain medical services and provides procedures to determine whether and how much money should be paid for patient care. The net effect of these direct benefits is to give the patients an opportunity to obtain medical services from providers of their choice that is comparable, if not exactly equal, to the opportunity available to persons who are financially independent. The Government cannot withdraw these direct benefits without giving the patients notice and an opportunity for a hearing on the issue of their eligibility for benefits.

447 U.S. at 786-7. *See also Kane* v. *Perry*, 41 N.Y.2d 1051 (1977), *reversing on opinion at Special Term* (82 Misc.2d 1019) *and dissenting opinion at Appellate Division* (55 A.D. 678).[37]

---

[37] The issues at the statutory hearing are summarized earlier in this Brief, page 23 n.23. Federal regulations specifically discuss the hearing which "involves medical issues such as those concerning a diagnosis, an examining physician's report, or a medical review team's decision." 42 C.F.R. § 431.240(b). The State Department of Social Services must ensure that the facility staff physician or facility director or the attending physician "who is responsible" for the decision to move the patient appears at the hearing to defend the decision. 18 N.Y.C.R.R. § 358.9(g). An additional medical assessment of the patient's needs must be obtained if the State Hearing Officer thinks it necessary. 18 N.Y.C.R.R. § 358.16(d).

CONCLUSION

For the foregoing reasons, this Court should affirm the Judgment below and find that this case presents a justiciable controversy, that there is state action in a nursing facility's transfer of a Medicaid patient to a higher level of care with or without a Utilization Review Committee determination, and that there is state action or alternatively a federal and state law right to a hearing in a nursing facility's discharge or transfer to a lower level of care of a Medicaid patient without a Utilization Review Committee determination.

Respectfully submitted,

KALMAN FINKEL
Attorney-in-Charge
The Legal Aid Society
Civil Division

JOHN E. KIRKLIN
Director of Litigation
The Legal Aid Society
Civil Appeals & Law Reform Unit
11 Park Place, 8th Floor
New York, New York 10007
(212) 227-2755
[Counsel of Record]

DAVID GOLDFARB
Attorney-in-Charge
The Legal Aid Society
Bronx Neighborhood Office

CHARLES ROBERT
91 North Franklin Street
Room 205
Hempstead, New York 11550
Attorneys for Respondents

Corrected

No. 80-1952

IN THE

Supreme Court of the United States

October Term, 1981

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, M.D., as Commissioner of the New York State Department of Health,

Petitioners,

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

REPLY BRIEF FOR PETITIONERS

ROBERT ABRAMS
Attorney General of the
State of New York
Attorney for Petitioners
Two World Trade Center
New York, New York 10047
(212) 488-2462

PETER H. SCHIFF
Acting Attorney-in-Chief
Appeals and Opinions Division

JUDITH A. GORDON
ANDREA G. IASON
Assistant Attorneys General
of Counsel

TABLE OF CONTENTS

PAGE

A. No respondent, intervenor or class representative was injured or threatened with injury by the private physician and nursing home transfers to different levels of care or by the Utilization Review Committee transfers to higher levels of care on review 2

B. State action is not involved in private physician and nursing home transfers of Medicaid patients to different levels of nursing home care or in Utilization Review Committee transfers of these patients to higher levels of care 8

Conclusion 20

TABLE OF AUTHORITIES

PAGE

Cases:

Allee v. Medrano, 416 U.S. 802 (1974) 6

Burton v. Wilmington Parking Authority, 365 U.S. 715 (1961) 8, 18

Cape Cod Nursing Council v. Rambling Rose Rest Home, 667 F.2d 238 (1st Cir. 1981) 19

Flagg Brothers, Inc. v. Brooks, 436 U.S. 149 (1978) 10, 18

Flast v. Cohen, 392 U.S. 83 (1968) 2

Gladstone Realtors v. Village of Bellwood, 441 U.S. 91 (1979) 3

Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974) ..... *passim*

Moose Lodge No. 107 v. Irvis, 407 U.S. 163 (1972) 11

Musso v. Suriano, 586 F.2d 59 (7th Cir. 1978), *cert. den.*, 440 U.S. 971 (1979) 18

O'Shea v. Littleton, 414 U.S. 488 (1974) 4

Polk County v. Dodson, —— U.S. ——, 50 U.S.L.W. 4077 (Dec. 14, 1981) 11

RAM v. Blum, 432 N.Y.S.2d 892 (App. Div. First Dep't 1980) 19

Robinson v. Wood, 464 F. Supp. 983 (E.D. Ill. 1979) 17

Valley Forge Christian College v. Americans United for Separation of Church and State, Inc., —— U.S. ——, 50 U.S.L.W. 4103 (Jan. 12, 1982) 2, 3

PAGE

Federal Statutes:

42 U.S.C.:
§ 1396a 12, 18
§ 1396b 12
§ 1396d 12

State Statutes:

New York Public Health Law:
§ 2801-d 17

New York State Constitution:
Article 17, §§ 1, 3 19

Federal Regulations:

42 C.F.R.:
§ 405.1121 17
§ 431.213 16
§ 431.220 ..... 16, 17
§ 442.306 12
§ 442.311 17
§ 456.260 12
§ 456.270 12
§ 456.280 13
§ 456.305-.306 11
§ 456.320 12
§ 456.331-.338 11
§ 456.360 12
§ 456.380 13
§ 456.405-.407 11
§ 456.431-.438 11
§ 456.606 14

PAGE

State Regulations:

10 New York Code Rules and Regulations:
§ 414.4 17
§ 415.1 ..... 12, 13
§ 416.1 14
§ 416.9 ..... 11, 12, 14
§ 420.1 ..... 12, 13
§ 421.3 14
§ 421.13 ..... 11, 12, 13, 14
§ 704.1 13
§ 730.2 12
§ 741.13 13
18 NYCRR § 360.29 18

No. 80-1952

IN THE

Supreme Court of the United States

October Term, 1981

BARBARA BLUM, as Commissioner of the New York State Department of Social Services; DAVID AXELROD, M.D., as Commissioner of the New York State Department of Health,

Petitioners,

against

WILLIAM YARETSKY, RALPH CUEVAS, and THE GRAY PANTHERS, NEW YORK CHAPTER,

Respondents,

and

MARY FOLEY, RAE WOLPER, ROSE SHULMAN, BESSIE ROSSOFF, PAULINE ASHKENAZY, SADIE BIRENZWEIG, MARTHA ZAHL, EDNA KOLMAN, JAMES LUNDY and PHILOMENA LATONA LUNDY, on behalf of themselves and all others similarly situated,

Intervenors-Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

REPLY BRIEF FOR PETITIONERS

A. No respondent, intervenor or class representative was injured or threatened with injury by the private physician and nursing home transfers to different levels of care or by the Utilization Review Committee transfers to higher levels of care on review.

Respondents' assertion that the transfers on review present a justiciable controversy and, therefore, satisfy Article III jurisdiction, misses the point.* The requirement of standing "focuses on the party seeking to get his complaint before a federal court and not on the issues he wishes to have adjudicated." *Flast* v. *Cohen*, 392 U.S. 83, 99 (1968). The parties and class representatives before the district court in this case were the named respondents and intervenors, and they complained only about URC transfers to lower levels of care. Their claims were finally determined by the October 17, 1979 Partial Final Judgment (A. 227). See main brief, pp. 8-13, 16-17, 26-28.** Although respondents and intervenors may have wanted to litigate one or more of the numerous statutory and constitutional questions that may be involved in the private physician and nursing home transfers to different levels of care or in the URC transfers to higher levels of care on review, none had standing to do so because none complained that he was transferred or threatened with transfer in this manner. See *Valley Forge Christian College* v. *Americans United for Separation of Church and State, Inc.*, —— U.S. ——, 50 U.S.L.W. 4103, 4105 (Jan. 12, 1982) and main brief, pp. 25-28.

---

* In this brief, the term "transfers" includes discharges from nursing home care unless otherwise specified in the text. See petitioners' brief ("main brief"), p. 7 & n.*.

** Respondents (brief, pp. 2, 7 n.6, 15-16, 18-19) concede that URC transfers to lower levels of care are not on review.

Respondents (brief, pp. 2-6, 15-16) attempt to avoid this result by claiming that they, the intervenors or other class members, have been subject to continuing threats with respect to the transfers in issue, although they did not complain about them below. These alleged threats are either non-existent or speculative and, therefore, do not present the prospect of "distinct and palpable injury" Article III requires. See *Valley Forge Christian College* v. *Americans United for Separation of Church and State, Inc., supra*, at 4106; *Gladstone Realtors* v. *Village of Bellwood*, 441 U.S. 91, 99 (1979); main brief, p. 25.

Respondents first argue that although their own URC transfers to lower levels of care and those of the intervenors were enjoined by the October 17, 1979 Partial Final Judgment (A. 227) (as well as by earlier orders, brief, pp. 1-2), they remained subject to continuing threats of transfers by their nursing homes based on the same URC decisions (brief, pp. 3, 15-16, 19-20).* These alleged threats do not withstand scrutiny.

Respondents concede that the proprietors and administrators of all nursing homes in New York (in addition to

* Respondents (brief, pp. 18-20) offer an apparent variant of this argument when they claim the continuing threats of transfers, to which they were subject by reason of the injunctive orders in this case, extended to all adverse URC transfers, including URC transfers to higher levels of care. This argument falls of its own weight. Since the injunctive orders on which respondents rely in this context restrained only URC decisions transferring Medicaid patients to lower levels of care (discussion above and at p. 4), respondents' and intervenors' nursing homes could not threaten them with transfers to higher levels of care based on these same URC decisions. Indeed, nursing homes never had occasion to threaten patients with transfers to higher levels of care, which could not be accomplished by enjoined URCs, since nursing home transfers to higher levels of care were both enjoined by the December 13, 1979 Partial Final Judgment (A. 241-43) which was affirmed by the opinion and judgment on review (A. 245).

the petitioners) were enjoined from implementing URC transfers to lower levels of care (without certain procedural rights) by temporary restraining orders (*e.g.*, A. 45-46) and by the January 5, 1978 preliminary injunction (A. 100-102) issued at the outset of this case (brief, pp. 2, 19 n.15).* As a result, nursing homes could not permit URC transfers of Medicaid patients to lower levels of care and could not adopt these URC decisions as their own initiatives as respondents' argument would require. If it is assumed that nursing homes were free to adopt the URC transfer decisions as their own, neither the record nor the papers before the Court suggest that they did so or threatened to do so. Indeed, respondent Yaretsky remained in the American Nursing Home for one and one-half years (without court order) after the URC decision transferring him to a lower level of care was affirmed by the New York State Department of Social Services. Petition, p. 4 n.*.** At the time the petition was filed, respondent Cuevas had stayed in American for five years after the URC decision transferring him to a lower level of care was affirmed by the Department. *Ibid.*

If respondents' argument is intended to show that nursing homes, like the respondents' and intervenors' own physicians, were free to transfer them for reasons outside the orders cited above, *i.e.*, for reasons other than the URC decisions transferring them to lower levels of care, they are

* The preliminary injunction was later affirmed by the Court of Appeals (A. 122).

** According to the Petition (*ibid.*), Yaretsky was transferred from American to Bellevue Hospital in mid-1977. His nursing home to hospital transfer is not among the patient transfers considered in this case.

correct. Both physicians and nursing homes always were, and continue to be (until the opinion and judgment on review), free to transfer their patients, based on their own judgments and subject only to applicable federal and state laws and professional ethics. The possibility that the respondents or intervenors might be subject to other transfers, in addition to the URC transfers they placed before the district court, does not afford them standing with respect to the other transfers. As shown (pp. 2-3, 5-7) and in the main brief, pp. 26-28, respondents and intervenors did not, and do not now, show that they were subject to or threatened with other transfers, and their rights, with respect to the URC transfers with which they were in fact involved, were finally determined by the October 17, 1979 Partial Final Judgment (A. 227).*

Respondents (brief, p. 20) next argue that if the physician, nursing home and URC transfers in issue cannot be attributed to respondents and intervenors themselves, they can be attributed to the class they represent. The argument fails immediately because a class member's standing does not exceed that of his class representative, and respondents and intervenors were the only class representatives before the court. *O'Shea* v. *Littleton*, 414 U.S. 488, 494 (1974);

* Respondents' (brief, pp. 18, 19 n.16) two passing references to the Gray Panthers in their standing argument add nothing. Respondents have yet to address petitioners' point that the Gray Panthers were excluded from the litigation of the transfers in issue by the terms of the Pretrial Order (A. 150 ¶A; 151 ¶B) and the December 13, 1979 Partial Final Judgment (A. 241-42 ¶2). See main brief, p. 29. Respondents' reliance on *United States* v. *SCRAP*, 412 U.S. 669, 688 (1973), is inapposite since petitioners put the Gray Panthers' standing in issue when it was first alleged (A. 35 ¶ *Third*; A. 37 ¶ *Fourteenth*), and there was no need to pursue the matter with respect to the transfers in issue since the organization had already been excluded by the Pretrial Order.

main brief, pp. 8, 15, 29. As stated in *Allee* v. *Medrano*, 416 U.S. 802, 828-29 (1974) (BURGER, C.J. concurring): "[A] person cannot predicate standing on injury which he does not share. Standing cannot be acquired through the back door of a class."

The several references in respondents' brief (pp. 2, 6, 20) to individuals other than the respondents and intervenors also fail in their purpose of identifying a class representative or member who has standing to contest the transfers in issue. Respondents first refer to "several cases of facility threats outside of the . . . (UR) process" (brief, p. 2) which were moot before the transfers in issue were first raised in the October 17, 1979 Partial Final Judgment (A. 227). *Ibid.*

Respondents (brief, pp. 6, 20) next refer to three letters, outside the record, from New York State Department of Health employees to nursing home employees.* Two letters identify Medicaid patients who were to be transferred from their nursing homes by their private physicians and advise the nursing home employees that the patients are to receive notice and opportunity for hearings (Ruid letters). The third letter does not identify any patient but says the same thing in response to a particular inquiry (Maddaloni letter). Since the letters show, in terms, that they were written after the transfers in issue were adjudicated by the December 13, 1979 Partial Final Judgment (A. 241) and that they were intended to assist in implementing that judgment, they cannot be said to identify any class member who had standing to contest the transfers before the dis-

* The letters are attached to respondents' brief in opposition to the petition.

trict court. Of further interest, since the letters are devoted to procedures required by the judgment, they give no indication of whether the two patients identified wanted pre-transfer notice and hearing or would have preferred to do without them.

Respondents (brief, p. 5) refer last to ten Medicaid patients, identified during discovery, who had fair hearings on their URC transfers to higher levels of care during a brief period prior to December, 1978, when State policy required such hearings. See main brief, p. 13 n.**; A. 181 ¶G(IV)(58), (59). As appears, these individuals cannot be identified as class members with standing since they, like the individuals cited in respondents' first two references, had the relief the class sought.

Respondents' (brief, pp. 16, 20-21) final standing argument fares no better than the others. Petitioners did not "stipulate" to the inclusion of the transfers in issue in the Pretrial Order (respondents' brief, pp. 4, 5, 16, 20-21). Respondents merely alleged those claims in the order which were, in turn, subject to all appropriate defenses. Nor did petitioners "stipulate" to the expanded definition of the class in the Pretrial Order (respondents' brief, pp. 4, 5, 16, 20-21). However, the point need not be resolved. As shown, pp. 5-6, and in the main brief, pp. 25 n.*, 29, the standing of a class is determined by the standing of the parties or class representatives. If, as in this case, standing of the parties and representatives is jurisdictionally deficient under Article III, standing of the class is also deficient, and its jurisdictional deficiency cannot be waived by agreement of counsel.

B. State action is not involved in private physician and nursing home transfers of Medicaid patients to different levels of nursing home care or in Utilization Review Committee transfers of these patients to higher levels of care.

Respondents' state action argument first characterizes the private physician, nursing home and URC transfers on review as "involuntary out-of-facility transfers by nursing facilities" (brief, p. 22 n.21) and then argues that state action is present in them, as well as in *"all"* like transfers (*ibid.*, emphasis original), on the theory that the nursing facilities are either required or encouraged to make the transfers by specific federal and state laws or by their interdependent relationship with the state (brief, pp. 17-18, 21-28). *Jackson* v. *Metropolitan Edison Co.*, 419 U.S. 345 (1974), and *Burton* v. *Wilmington Parking Authority*, 365 U.S. 715 (1961), are the principal cases cited in support of the alternative rationales (brief, pp. 23-25, 28-32).*

---

* Respondents include transfers that result from the following decisions in the class of *"all* involuntary out-of-facility transfers" (brief, p. 22 n.21, emphasis original) and assert that they are before the Court for review (brief, p. 22 & n.20): any "medical decision of a facility staff physician, the patient's attending physician, the facility medical director, or (in some transfers to a higher level of care) a URC determination" and any "purely non-medical decision of a facility operator that the patient is troublesome, antisocial, disturbed, or just plain undesirable."

Medical decisions transferring patients "out-of-facility" but within the same level of care, included in the preceding list, are not before the Court for review. The December 13, 1979 Partial Final Judgment (A. 242-43), as well as the opinion below (A. 247, 248-50), exclude these "lateral" medical transfers, and the Court of Appeals state action analysis depends on the exclusion. A. 247, 248-50 and main brief, pp. 21, 23-24, 32-34, 35-37. *Contrast* respondents' brief, pp. 22 n.20 & n.21.

The "purely non-medical decisions" included in the list were not addressed below except insofar as they involved an assessment

(footnote continued on next page)

The argument is specious in all material respects. The constraints of state action analysis do not permit respondents to attribute the private physician and URC decisions they describe to nursing homes any more than they permit respondents to attribute all medical (or non-medical) decisions by nursing homes to the state. The same constraints preclude respondents from relying on a patient's disagreement with these decisions as the touchstone for state action since the decisions must be identified with the state before the question of deprivation of rights is addressed.

The medical decisions of private and "attending" physicians to change their patients' levels of care and those of URCs to move their patients to higher levels of care cannot become "nursing facility transfers" in respondents' lexicon simply because a nursing home permits these private initiatives to be implemented.* Even if the nursing home were the state itself, its conduct in this regard would be no more than acquiescence in private action and would not provide any basis for attributing the physician and URC decisions

---

of a patient's medical needs. *Contra* December 13, 1979 Partial Final Judgment (A. 242-43) with respondents' brief, p. 22 n.20). To the extent that they may be read into the judgment, they are subject to the same Article III deficiencies as respondents' claims against the physician, nursing home and URC transfers based on medical decisions. See subpoint A and main brief, Point I. Further, they are not decisions involving state action and are not the appropriate subject of "fair hearings."

* Respondents do not challenge the Court of Appeals findings (A. 126, 249-50) that the physicians and URCs in question are private parties and that their decisions about the level of care their Medicaid patients should receive are free of state action when made (A. 126, 249-50). Their assertion (brief, p. 19 n.14) that the nursing home, not the physician or the URC, actually discharges patients only evidences the fact that the home is implementing the prescribed change in care, not that it is initiating the change or is responsible for the patient's dissatisfaction with the decision. *Contra* respondents' brief, pp. 19 n.15, 20.

to the home. *Jackson, supra,* at 357-58; *Flagg Brothers, Inc.* v. *Brooks,* 436 U.S. 149, 164-66 (1978). Further, since the transfers are private initiatives and are identified with nursing homes only by reason of the latter's acquiescence, they must be excluded from the class of nursing facility transfers relied on in respondents' principal *Jackson* argument, *i.e.,* those affirmatively commanded encouraged by federal and state laws. *Contrast* respondents' brief, pp. 17, 23-25.

Although a nursing home's own medical decisions to change its patients' levels of care (made by a "facility staff physician" or a "facility medical director," respondents' brief, p. 22) as well as its non-medical transfer decisions (made by a "facility operator," *ibid.*), are nursing facility transfers, as respondents use that term, they do not involve state action. As the Court made clear in *Jackson, supra,* at 351, 357, a private party's exercise of its own initiative in making choices allowed by state (or federal) law is not conduct which can be attributed to the state itself absent a showing that the state has ordered, or at least acted affirmatively, with respect to the choice in question.

The array of federal and state laws respondents cite to show that the *Jackson* standard applies in their favor because the state either affirmatively commands the nursing home to make the transfers in question (brief, pp. 17, 23-25) or reviews and approves or rejects them (brief, pp. 17-18, 26-27) does not serve that purpose. Rather, as shown below, these laws, when relevant at all, demonstrate that the state (and federal government) leave nursing homes (as well as physicians and URCs) free to assess their patients' medical needs and to decide for themselves whether the patients

should be transferred to different levels of nursing home care or discharged from that kind of care. As a result, *Jackson*, as well as *Polk County v. Dodson*, ___ U.S. ___, 50 U.S.L.W. 4977 (Dec. 14, 1981) and *Moose Lodge No. 107 v. Irvis*, 407 U.S. 163, 172 (1972), require a finding that no state action is present in the transfers on review. *Contra* respondents' brief, pp. 17 n.24, 25.

The first federal and state law citations which respondents provide to support their argument that the state affirmatively commands nursing home to make the transfers in issue largely describe admissions rather than continued stays,* transfers, or discharges, and speak in broad terms, *i.e.*, SNFs and ICFs** are to admit only those patients for

* Respondents' use of the term "continued stay" (as well as some of their references) opposes their claim (brief, pp. 7 n.6, 9 n.12, 17) that they are relying on federal and state laws which are outside the utilization review. Continued stay review is required by, and is part of utilization review ("UR"), 42 C.F.R. §§ 456.131, 456.328, 456.333, 456.432; 10 New York Code Rules and Regulations ("NYCRR") §§ 416.9(b), 421.13(b). If respondents are attempting to distinguish UR from utilization review committees ("URC's), possibly because of the Court of Appeals finding that URC decisions are private acts (A. 249-50), their distinction is false. URC's and their decisions are part of UR. See 42 C.F.R. §§ 456.305, 456.306, 456.307, 456.307; 10 NYCRR §§ 416.9, 421.13.

** Respondents refer to the nursing homes that offer a less intensive level of nursing care by their federal term, ICFs, rather than their New York term, HRFs. Their usage is followed here. Their federal and state laws discussion (brief, pp. 7-15) also includes numerous references to the federal Medical Assistance Manual and to state administrative memoranda. The state memoranda (albeit not the federal manual) are said to have the force and effect of law (brief, p. 9 n.10 & n.11). Neither the federal manual nor the state memoranda have such an effect. They merely interpret controlling laws and regulations and are disregarded in this discussion. Petitioners' attorneys have in fact reviewed all the interpretative material respondents cite (except for HHS Manual § 6-9-20, quoted in respondents' brief, p. 11, as § 00-90-20) and have found that material consistent with their discussion of the federal and state laws involved.

whom they can provide care (42 C.F.R. § 442.306; 10 NYCRR §§ 415.1(b), 420.1(d), 730.2(b) [parallel reference]*), and patients are to be evaluated for admission in terms of their need for the care SNFs and ICFs provide. 42 C.F.R. §§ 456.270(a), 456.320(a). The requirement that a patient who is, or wants to be, Medicaid-funded have his need for SNF or HRF services certified by a UR physician before payment is authorized and every sixty days thereafter is cited. 42 U.S.C. § 1396b(g)1(A),(B); 42 C.F.R. §§ 456.260(a), (b), 456.360(a), (b).** Emphasis is placed on the LongTerm Care Placement Form ("DMS-1") (and related Numerical Standards Master Sheet ["DMS-9"]) which New York requires for all admissions (brief, p. 8).† The forms are intended to assist and inform medical decision-makers about the intensity of nursing home care a patient needs, if any, not to make the decision about care for them. Thus, the various weights assigned to

* Regulations in the 700 series of Title 10, NYCRR, generally restate regulations in the 400 series, and duplicative references to the 700 series in respondents' brief are disregarded hereafter. Citation to the 400 series is to be preferred because that series defines the minimum standards upon which certificates of operation depend. To the extent the 700 series is not duplicative of the 400 series, it is viewed as unenforceable by the administering agency.

** An individual must meet two essential conditions to obtain Medicaid. He must be eligible in terms of income and resources (42 U.S.C. §§ 1396a[1], 1396a[a][10]), and he must need medically necessary services. 42 U.S.C. §§ 1396a[1], 1396d[4][A], [c]. The physician certification requirement which respondents identify implements the medically necessary requirement of the program. It is the only law cited in respondents' discussion and here that applies exclusively to Medicaid patients in New York. All other laws, including UR review, apply to both private and publicly assisted patients. 10 NYCRR §§ 416.9, 421.13. See Joint Statement of Facts ¶ G(H)(16) (A. 170) erroneously stating the contrary with respect to UR. *Contrast* Brief *Amicus Curiae*, Point III.

† The forms are reproduced in Appendix C-1 to Title 10 (Vol. C), NYCRR.

medical conditions and related circumstances do not impose a "cut-off score" on the decision maker or on the patient's access to care. *Contrast* respondents' brief, p. 8 n.8. As appears from the controlling regulations, a physician's certification of a patient's need for care always overrides a "low" score on the forms. 10 NYCRR §§ 415.1(a)(2), 420.1(b)(2).

When respondents turn to transfers and discharges specifically (brief, pp. 8-9), they again cite broadly framed regulations which permit SNF's and HCF's to admit and "retain" only those patients for whom they can provide care (10 NYCRR §§ 415.1[b], 420.1[a][1][11],421.13[d]), as well as several which require that patients, who are dangerous, have communicable diseases, etc., to be transferred to other settings. 10 NYCRR §§ 415.1(i), 420.1(i)(2)-(4).* The discharge planning regulations respondents cite (brief, pp. 8-9), and upon which their argument that federal and state laws command the discharges in question would appear to depend, do not so command. The federal regulations require SNF's and HCF's to have "plans for discharge" without more. 42 C.F.R. §§ 456.280(b)(6), 456.380(b)(6). The state regulations (for SNF's) cited say that the "patient care and discharge plan" must be provided by the patient's "personal, alternate or staff physician," working with others, and "summarize," *inter alia*, "the patient's potential for return to the community, for transfer to another more appropriate setting or for achieving or maintaining the best obtainable level of function in the nursing

Two non-duplicative regulations in the 700 series of Title 10, NYCRR (see p. 12 n.) are cited (brief, p. 9). They are intended to assure that HCF patients have access to more intensive nursing and medical services if they need them (§ 741.13[a][3]) and that patients are transferred among licensed facilities (§ 766.1[b][2]).

home." 10 NYCRR § 416.1(k)(2)(ii). The HRF regulation, 10 NYCRR § 421.3(a), (b), is identical in all material respects. The state UR regulations cited (brief, p. 9) simply require SNF and HRFs to have orderly discharge procedures and to "complete" the DMS-1 and DM-9 forms discussed earlier. 10 NYCRR §§ 416.9(d), 421.13(d). The memoranda cited at the conclusion of the respondents' discussion (brief, p. 10) do not require nursing homes to rely on the forms for admissions purposes, they simply permit them to do so, and no federal or state law directs nursing homes to admit particular patients, or directs patients to particular nursing homes. *Contrast* respondents' brief, pp. 11-12, 24-25, 27, 30.

The second federal and state law citations which respondents provide (brief, pp. 10, 24) to support their argument that the state commands nursing homes to make the transfers in issue are completely inapposite. States are, as respondents claim, required to undertake annual on-site inspections of SNFs (PMR reviews) and ICFs (IPR reviews) to determine the "quality of care and services being provided . . . and the condition of the recipients" (42 C.F.R. § 456.606), and New York does so (A. 135-36).* It is possible, as respondents also claim, for an inappropriately placed patient to be discovered during an inspection and for the state investigating team, to recommend the patient's transfer or discharge to the nursing

* New York is currently "on waivers" from this regulation based on its conduct of an HHS approved demonstration project. However, it continues to make periodic quality assurance inspections. Those inspections examine care and services provided to private and publicly assisted nursing home patients as they have in the past.

home, or in an extraordinary circumstance, for state health officials to direct the transfer. No such state-initiated transfers are presented by the record in this case, and in the latter illustration, the Fourteenth Amendment inquiry would focus on whether the patient transferred by state health officials had been deprived of a protected liberty or property interest, a question not now before the Court. Similarly, if state officials decide to fine or decertify a nursing home for an abusive practice, for example, discharging, on medical grounds, patients who are appropriate for the level of care it provides and/or retaining others who are not, no problematic question of state action is presented. However, contrary to respondents' view (brief, pp. 17, 25), the laws which empower the state to proceed in this manner cannot be read as requiring the nursing home to engage in the very conduct, *e.g.*, transferring patients who are appropriately placed, that they are intended to punish.

Respondents' (brief, pp. 17-18, 26-27) attempt to show that the state acts affirmatively with respect to the transfers in issue (even if it does not command them) by reviewing and approving or rejecting physician, URC and nursing home decisions in particular cases fails entirely. The state certification that nursing home care is medically necessary is issued at, or before, admission and periodically thereafter while the patient remains in long-term care. See p. 12 & n.**. *Contrast* respondents' brief, pp. 12-13, 26. There is no certification requirement for transfers or discharges from care, and no certification is issued. The Department of Health does require that DMS-1 forms be com-

pleted and filed (respondents' brief, pp. 12, 26 n.25), including those issued during continued stay reviews where no transfer or discharge has occurred.* However, it does not review them, or the change in care, on the merits.** As established in the main brief, Point II, the adjustment in Medicaid benefits made by the Department of Social Services following a transfer is not an assessment of the merits of the change in level of care decision, it is an acceptance of that decision intact. *Contrast* respondents' brief, pp. 26-27. Indeed, the Department has no obligation to address the merits of these decisions except at the fair hearings mandated by the October 17, 1979 Partial Final Judgment in this case (A. 227) and by the opinion and judgment on review (A. 245) which affirmed the December 13, 1979 Partial Judgment (A. 241).†

---

* The Department has used the forms principally as a data base for statistically oriented studies about nursing home needs within the state.

** New York City Medicaid authorities reviewed URC transfers to lower levels of care at one time. This practice was discontinued in 1977 when the state took over the City's long-term care responsibilities. Main brief, p. 5 n.**.

† Respondents argue (brief, Point III) incorrectly that the Department's obligation to hear and determine the validity and appropriateness of the transfers in issue can be found in federal and state laws. Fair hearings in the Medicaid program are limited procedural vehicles which permit claimants to be heard on state agency decisions adverse to them that are within the power of the agency to redress. None of the regulations cited (brief, p. 5) oppose this principle, and thus none afford fair hearing rights on the non-agency transfer decisions in issue. *See, e.g.*, 42 C.F.R. § 431.220(a)(1) (agency did not decide transfers; no basis for a denial of a "claim for services" presented); *id.*, § 431.220(a)(2) (accuracy of agency's conforming adjustment of benefits after transfer, unchallenged; no basis for a claim of erroneous agency action presented). Reference (brief, p. 5) to 42 C.F.R. § 431.213(f) is not in point. The regulation exempts changes in levels of care prescribed by physicians from advance notice to recipients. It does not afford recipients a right to a fair hearing on the merits of the physician's decision. Its evident purpose is to

(footnote continued on next page)

Respondents (brief, pp. 11-12, 27) conclude their argument under *Jackson* by contending that the transfers on review oppose the state's alleged obligation to provide nursing home care for all Medicaid patients and its further alleged obligation to secure the free choice of those patients to remain in nursing homes once they have been submitted. The alleged obligations do not exist, and the physician, nursing home and URC transfers in question conform with the federal and state laws on which respondents must rely. The Medicaid program does not require states to provide SNF or ICF services or to guarantee all recipients a nursing home placement. It provides funding for certain services, including nursing home care offered by qualified providers, for individuals who have demonstrated both financial eligibility and a medical need for the service they seek. See p. 12 & n.2 and main brief, p. 4n.**. The question of medical need is determined in the first instance by a medical professional, and, if answered affirmatively by him, considered

---

enable the recipient to challenge the benefits he receives from the agency as erroneous under § 431.220(a)(2) if they do not reflect the change in care.

The patients' bill of rights, 42 C.R.F. §§ 405.1121(k)(4), 442.311(c); 10 NYCRR § 414.4(a)(4), repeatedly cited by respondents (brief, pp. 11-12, 23 n.23, 34 n.34) and the source of the "purely non-medical" transfers they contend are in issue (p. 8 n.* of this brief), does not provide fair hearing rights for recipients. It does provide for patient claims against their nursing homes, including the claim that a patient not be discharged except for "medical reasons, or for his welfare or that of other patients, or for nonpayment of his stay . . . ." 42 C.F.R. § 405.1121(k). *Roberson* v. *Wood*, 464 F. Supp. 983 (E.D. Ill. 1979). See also New York Public Health Law § 2801-d. This focus for patient/nursing home disputes is appropriate and should obtain with respect to the transfers in issue. Both parties are before the court, and relief which is both complete and enforceable can be awarded. The URC, the entity with which respondents and intervenors in fact have a dispute, is not a party to fair hearings, and the form of relief available there, adjustment in benefits, does not permit the respondents and intervenors to reverse the URC determination that they did not need SNF or ICF care.

by state Medicaid program personnel for certification purposes. See p. 12 & n.2. The free choice provisions, 42 U.S.C. § 1396a(a)(23); 18 NYCRR § 360.29, prohibit the state from restricting the individual's access to providers who offer services that are consistent with his demonstrated medical need. They do not permit the individual to determine his own need or require nursing home providers to admit or retain individuals, like respondents and intervenors, who do not have a medical need for the services the provider offers. As noted p. 16 n.†, if the individual wants to dispute a nursing home's judgment, or that of a physician or URC, his remedy is against those individuals and entities, and not in a proceeding against the state to obtain reimbursement for services that a provider has found that the individual does not need and that the state cannot force the provider to offer him.

Respondents' argument (brief, pp. 28-32) that proprietary and voluntary nursing homes in New York stand in a sufficient interdependant relationship with the state to find state action present under *Burton* v. *Wilmington Parking Authority*, *supra*, is foreclosed by the analysis of that case presented in *Jackson*. As the Court there found (419 U.S. at 357-58), privately-owned enterprises, operating on their own land and responsible for providing their own services, although extensively regulated, do not come under *Burton*. Proprietary and voluntary nursing homes in New York meet all the indicia *Jackson* cited in distinguishing *Burton*.

In addition, they do not perform any function traditionally associated with sovereignty, *Flagg Brothers Inc.* v. *Brooks*, *supra*, at 171, see *Musso* v. *Suriano*, 586 F.2d 59

(7th Cir. 1978), *cert. den.*, 440 U.S. 971 (1979) and cases cited in the main brief, p. 36, and are not "company towns." *Cape Cod Nursing Council* v. *Rambling Rose Rest Home*, 667 F.2d 238 (1st Cir. 1981). *Contrast* respondents' brief, p. 30 & n.31. Neither the Medicaid program nor state laws imposes any special duty on the state with respect to nursing home services for indigents which is executed by nursing homes. See pp. 17-18. *Contrast* respondents' brief, p. 30 & n.31.* The fact they receive federal and state monies does not identify them with the state for Fourteenth Amendment purposes. Main brief, p. 36 and cases there cited.**

---

* The New York Constitution, Art. 17, §§ 1, 3, merely authorizes the legislature to provide funds for the care of the needy in its discretion. *RAM* v. *Blum*, 432 N.Y.S.2d 892 (App. Div. First Dep't 1980). It does not mandate that any particular kind of care be provided much less long-term nursing home care.

** Proprietary and voluntary (not-for-profit) nursing homes are not guaranteed a profit under New York's reimbursement methodology. *Contrast* respondents' brief, p. 29.

CONCLUSION

For the foregoing reasons and those set forth in the Brief for Petitioners, the Judgment below should be vacated as entered without jurisdiction, or, alternatively, it should be reversed, and physician and nursing home transfers of Medicaid patients to different levels of care and discharges from care as well as Utilization Review Committee transfers of Medicaid patients to higher levels of care should be declared free of state action under the Fourteenth Amendment.

Dated: New York, New York
March 22, 1982

(This brief has been re-printed to conform with the text provided to printer by the attorneys for petitioners on March 19, 1982 and provided by said attorneys to John E. Kirklin, lead attorney for respondents, on that date.)

Respectfully submitted,

ROBERT ABRAMS
Attorney General of the
State of New York
Attorney for Petitioners
Two World Trade Center
New York, New York 10047
(212) 488-2462

PETER H. SCHIFF
Acting Attorney-in-Chief
Appeals and Opinions Division

JUDITH A. GORDON
ANDREA G. IASON
Assistant Attorneys General
*of Counsel**

* The Attorney General gratefully acknowledges the assistance of Joseph C. Bierman, Associate Counsel, New York State Department of Health, and Sheryl Krongold, Legal Assistant, New York State Department of Law, in the preparation of this brief.

MOTION FILED
JAN 20 1982

No. 80-1952

IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1981

BARBARA BLUM, *ET AL.*,
Petitioners,
v.
WILLIAM YARETSKY, *ET AL.*,
Respondents.

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE SECO.. ..CUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

TOBY S. EDELMAN
PATRICIA B. NEMORE
NATIONAL SENIOR
CITIZENS LAW CENTER
1424 16th Street, N.W.
Suite 300
Washington, D.C. 20036
(202) 232-6570
Attorneys for Amicus Curiae, National Citizens' Coalition for Nursing Home Reform

Washington, D.C. • THIEL PRESS • (202) 638-4521

TABLE OF CONTENTS

Page

MOTION OF NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS v

BRIEF *AMICUS CURIAE* OF NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM 1

INTEREST OF THE *AMICUS CURIAE* NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM 1

SUMMARY OF ARGUMENT 2

ARGUMENT:

I. The Skilled Nursing and Intermediate Levels of Care Are Statutory Constructs Created for Purposes of Fiscal Control in the Medical Assistance Program 3

A. Legislative History of Levels of Care 4

B. Levels of Care in Practice 10

II. Utilization Control Activities, Conducted by Facilities and Physicians, Enforce Level of Care Principles 11

III. Level of Care and Utilization Control Requirements Are Not Applied to Private-Pay Residents 14

IV. State Action Is Properly Found Whenever Level of Care Decisions Are Made by Utilization Review Committees, Facilities or Physicians 15

CONCLUSION 17

TABLE OF AUTHORITIES

Cases:

Beltran v. Myers, 101 S.Ct. 1961 (1981) 6, 8

Estelle v. Gamble, 429 U.S. 97 (1976) 16

***Cases**, continued:* *Page*

Flagg Brothers, Inc. v. Brooks, 436 U.S. 149 (1978) 15, 16

Jackson v. Metropolitan Edison Co., 419 U.S. 345 (1974) 15, 16

Moose Lodge v. Irvis, 407 U.S. 163 (1972) 16

O'Bannon v. Town Court Nursing Center, 447 U.S. 773 (1980) ..... *vi*

O'Connor v. Donaldson, 422 U.S. 563 (1975) 16

Polk County v. Dodson, 50 U.S.L.W. 4077 (Dec. 14, 1981) 16

Yaretsky v. Blum, 629 F.2d 817 (2d Cir. 1980) 2

Statutes:

42 U.S.C. § 1395x(h), (i) 4

42 U.S.C. § 1395x(j) 4, 12

42 U.S.C. § 1396a(a)(10)(A) 6

42 U.S.C. § 1396a(a)(10)(C) 8

42 U.S.C. § 1396a(a)(26) 12

42 U.S.C. § 1396a(a)(28) 12

42 U.S.C. § 1396a(a)(30) 12

42 U.S.C. § 1396a(a)(31) 12

42 U.S.C. § 1396b(g) 13

42 U.S.C. § 1396d(c)(1) 4, 12

42 U.S.C. § 1396d(f) 4

Regulations:

42 C.F.R. § 435.100 6

42 C.F.R. § 435.800 8

42 C.F.R. § 456.22 12

42 C.F.R. § 456.270 13

42 C.F.R. § 456.271 13

42 C.F.R. § 456.333 14

***Regulations**, continued:* Page

42 C.F.R. § 456.370 13
42 C.F.R. § 456.371 13
42 C.F.R. § 456.433 14
42 C.F.R. § 456.612 13
42 C.F.R. § 456.650 13
42 C.F.R. § 456.652 13

Rules:

Supreme Court Rule 42(1) . . . . . *v*

Miscellaneous:

Bishop, C., "Nursing Home Levels of Care: Problems and Alternatives," 2 *Health Care Financing Review* 33 (Fall, 1980) 10

Comptroller General, "Entering a Nursing Home—Costly Implications for Medicaid and the Elderly," PAD-80-12 (Nov. 26, 1979) 9, 14

113 *Cong. Rec.* 32599 (Nov. 15, 1967) 8

117 *Cong. Rec.* 44721 (Dec. 4, 1971) 8, 9

Mitchell, J., "Patient Outcomes in Alternative Long-Term Care Settings," 16 *Medical Care* 439 (June, 1978) 5

Moroney, R., et al., "The Evolution of Long-Term Institutions," in Sherwood, S., ed., *Long-Term Care: A Handbook for Researchers, Planners, and Providers* 105 (1975) 5, 6

Pollak, W., *Expanding Health Care Benefits for the Elderly. Volume 1: Long Term Care* 10 (1979) 6, 9, 11

S. Rep. No. 404 (Finance Comm.), 89th Cong., 1st Sess., reprinted in [1965] U.S. Code Cong. & Ad. News 1943 4

S. Rep. No. 744 (Finance Comm.), 90th Cong., 1st Sess., reprinted in [1967] U.S. Code Cong. & Ad. News 2834 . . . . . 5, 6, 7

***Miscellaneous**, continued:* *Page*

Subcomm. on Long-Term Care, Senate Comm. on Aging, *Nursing Home Care in the United States: Failure in Public Policy. Supporting Paper No. 3: Doctors in Nursing Homes: The Shunned Responsibility*, 94th Cong., 1st Sess. (Feb., 1975) 2

Vladeck, B., *Unloving Care—The Nursing Home Tragedy* (1980) 5, 6, 10, 11

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

BARBARA BLUM, *ET AL.*,

Petitioners,

v.

WILLIAM YARETSKY, *ET AL.*,

Respondents.

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

To the Honorable Chief Justice
and Associate Justices of the
Supreme Court of the United States

The National Citizens' Coalition for Nursing Home Reform respectfully moves this Court, pursuant to Supreme Court Rule 42(1), for leave to file the accompanying brief in this matter as *amicus curiae* in support of respondents. In support of this motion, the Coalition submits the following statement:

The National Citizens' Coalition for Nursing Home Reform, formed in 1975, is a national organization comprised of one hundred seven local community advocacy groups and many individuals who are actively involved in issues of nursing home reform and advocacy throughout the United States. The Coalition's goal is improving the quality of life for the 1.3 million people, five percent of the nation's elderly population, who live in nursing homes. The Coalition has particular interest in questions concerning empowerment of nursing home residents, quality of life and care in nursing homes, and enforcement of federal and state nursing home laws and regulations. The Coalition participated as *amicus curiae* in *O'Bannon v. Town Court Nursing Center*, 447 U.S. 773 (1980), the first case before this Court addressing issues of nursing home residents' rights.

The Coalition in a brief *amicus curiae* wishes to address the state action issue before the Court and specifically to set forth the legislative history of the skilled nursing and intermediate levels of care that are at issue. This legislative history shows that level of care determinations made by nursing homes and physicians are not part of any historical practice in long-term care, but rather, are statutory terms that were invented by Congress and enacted for purposes of fiscal control. It indicates that level of care determinations are made solely because of statutory directive and not because of traditional health care practice. This legislative history is relevant both to refuting petitioners' claim that level of care determinations are medical decisions and to showing how a finding of state action in level of care determinations is required by this Court's state action decisions.

Respondents consent to the filing of this brief *amicus curiae.* It is the policy of petitioners, New York State, however, not to take any position on motions for leave to file briefs *amicus curiae.*

Respectfully submitted,

By _____

TOBY S. EDELMAN
PATRICIA B. NEMORE

NATIONAL SENIOR
CITIZENS LAW CENTER
1424 16th Street, N.W.
Suite 300
Washington, D.C. 20036
(202) 232-6570

Attorneys for Amicus Curiae,
National Citizens' Coalition
for Nursing Home Reform

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1981

BARBARA BLUM, *ET AL.*,

Petitioners,

v.

WILLIAM YARETSKY, *ET AL.*,

Respondents.

ON WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

BRIEF *AMICUS CURIAE* OF THE NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

INTEREST OF *AMICUS* NATIONAL CITIZENS' COALITION FOR NURSING HOME REFORM

The National Citizens' Coalition for Nursing Home Reform is a national organization comprised of one hundred seven local community advocacy groups and many individuals who are actively involved in issues of nursing home reform and advocacy throughout the United States. Of particular interest to the Coalition are questions concerning empowerment of nursing home

residents, quality of life and care in nursing homes, and enforcement of federal and state nursing home regulations.

This case, involving the issue of state action in long-term care facilities, is of particular importance to Coalition members.

SUMMARY OF ARGUMENT

The Second Circuit in the decision below recognized that whenever long-term care facilities or physicians make decisions to transfer Medicaid-supported nursing home residents to new facilities providing a different level of care, those decisions affect the enjoyment of public benefits and therefore must comport with Constitutional standards. *Yaretsky v. Blum*, 629 F.2d 817, 819-820 (2d Cir. 1980).

Petitioners argue that level of care decisions made by facilities, physicians or utilization review committees (when the decisions result in transfers to higher levels of care) are medical decisions not involving state action. By labeling all level of care decisions "medical," petitioners attempt to suggest that the decisions are part of traditional practices and not dependent on state authority. The falseness of petitioners' argument is revealed, however, by the breadth of their claim. It cannot be reasonably contended that level of care decisions made by facilities are medical. Indeed the documented absence of medical practitioners from long-term care facilities[1] makes plain the inaccuracy of that claim.

---

[1] Subcomm. on Long-Term Care, Senate Comm. on Aging, *Nursing Home Care in the United States: Failure in Public Policy. Supporting Paper No. 3: Doctors in Nursing Homes: The Shunned Responsibility*, 94th Cong., 1st Sess. (Feb. 1975).

More fundamentally, petitioners' argument must fail because petitioners misconstrue levels of care and the level of care decision-making process.

Skilled nursing and intermediate levels of care, enforced through utilization control mechanisms, are creations of the Medical Assistance statute. Both concepts were placed in the Medicaid law in order to promote primarily fiscal goals. Neither has any basis in the traditional practice of medicine in long-term care, and, as a result, neither is ever applied to residents who pay personally and directly for their long-term institutional care.

Since level of care determinations are statutorily-directed administrative functions, whoever makes these determinations is performing an administrative function. While nursing homes and physicians may in other instances in the long-term care setting be performing traditional long-term care or medical functions, whenever they are engaging in level of care decision-making, they are performing administrative functions to which a finding of state action properly attaches.

ARGUMENT

I.

THE SKILLED NURSING AND INTERMEDIATE LEVELS OF CARE ARE STATUTORY CONSTRUCTS CREATED FOR PURPOSES OF FISCAL CONTROL IN THE MEDICAL ASSISTANCE PROGRAM.

The Medical Assistance Program reimburses nursing homes for providing nursing home care to Medicaid recipients if the care is provided at the skilled nursing or intermediate care level. A skilled nursing facility (SNF) is defined as providing "skilled nursing care . . . or

other skilled rehabilitation services which as a practical matter can only be provided in a skilled nursing facility on an inpatient basis." 42 U.S.C. § 1396d(f).[2] An intermediate care facility (ICF) is defined as one which provides "health-related care and services" at a lesser level of intensity than a skilled nursing facility offers. 42 U.S.C. § 1396d(c)(1).

Petitioners argue that decisions involving changes in level of care for nursing home residents do not implicate state action doctrine. Critical to their argument is the thesis that level of care decisions are medical decisions which the State simply honors by adjusting Medicaid payments made on recipients' behalf. This thesis is both factually inaccurate and fatal to defendants' state action analysis.

A. Legislative History of Levels of Care

The legislative history of the two levels of institutional long-term care makes plain that cost containment, rather than recognition of concepts of medical practice, motivated legislation in this area.

When Congress initially enacted the Medical Assistance Program in 1965, it authorized reimbursement for one

---

[2] Medicare created a level of long-term care originally called "extended care." Social Security Amendments of 1965, § 102, 42 U.S.C. § 1396x(h), (i), (j). Congress was motivated by economic factors. "Care in an extended care facility will frequently represent the next appropriate step after the intensive care furnished in a hospital and will make unnecessary what might otherwise possibly be the continued occupancy of a high-cost hospital bed which is more appropriately used by acutely ill patients." S. Rep. No. 404 (Finance Comm.), 89th Cong., 1st Sess., reprinted in [1965] U.S. Code Cong. & Ad. News 1943, 1971. In contrast to Medicaid, however, Medicare has never been extended to cover a lower level of long-term institutional care.

level of institutional long-term care called skilled nursing care. 42 U.S.C. §§ 1396a(a)(28), 1396d(f).[3] The Congressional purpose of creating such a level of care was to reduce the need for more costly care in acute care hospitals.[4]

From almost the moment of its enactment, Congress became concerned with the cost of the Medical Assistance Program. A 1967 Senate Finance Committee report accompanying amendments to the Social Security Act noted, "The committee has followed the developments of the medical assistance program with deep concern over its rapidly rising costs."[5] At that time, only two years after the enactment of Medicaid, Congress began to implement a series of cost-savings measures, such as

---

[3] In fact there was little discussion of the Medical Assistance Program in the 1965 amendments to the Social Security Act which created it. Medicaid was the "sleeper" amendment appended to the administration's Medicare bill. Within Medicaid itself, little attention was paid to nursing homes at all. Vladeck, B. *Unloving Care—The Nursing Home Tragedy* 50, 48 (1980).

[4] "*Cost efficiency* constituted the Congressional rationale for financing care outside acute facilities, and federal legislation was not guided by any documentation of the *therapeutic effectiveness* of such care." [Emphasis in original.] Mitchell, J., "Patient Outcomes in Alternative Long-Term Care Settings," 16 *Medical Care* 439, 440 (June, 1978). Other authors have also concluded that concern over rising acute care hospital costs motivated Congressional enactment of long-term care in nursing homes. *See*, for example, Moroney, R., et al., "The Evolution of Long-Term Care Institutions" in Sherwood, S., ed., *Long-Term Care: A Handbook for Researchers, Planners, and Providers* 105 (1975).

[5] S. Rep. No. 744 (Finance Comm.), 90th Cong., 1st Sess., reprinted in [1967] U.S. Code Cong. & Ad. News 2834, 3013.

limitations on federal financial participation for the medically needy program[6] and the requirement that states provide home health benefits for persons eligible for skilled nursing facility services.[7] Congress also created a new lower level of institutional long-term care, which it called intermediate care, for categorically needy recipients.[8]

Congressional motivation was explicitly financial.[9] The Senate Finance Committee Report on the Social Security Amendments of 1967, P.L. 90-248, expressed concern with the fact that only skilled nursing care was reimbursable under Medicaid. The result, the Committee reported, was that Medicaid recipients were classified as needing "skilled nursing home" care "and placed in such institutions because of a decided financial advantage to a State under present matching formulas."[10] The overutilization of skilled nursing facilities suggested to the Committee that "a strong case exists for introducing another level of care for which vendor payments would be available."[11] The Miller amendment proposed by the Senate and adopted by Congress created this new level of care under Title XI of the Social Security Act, which

---

[6] *Id.*, at 3013.

[7] *Id.*, at 3029.

[8] Categorically needy Medicaid recipients are those whose eligibility is based on their receipt of cash assistance benefits. 42 U.S.C. § 1396a(a)(10)(A), 42 C.F.R. §§ 435.100 et seq. Coverage of these persons is mandatory in the Medical Assistance Program. *See Beltran v. Myers*, 101 S.Ct. 1961 (1981).

[9] Pollak, W., *Expanding Health Benefits for the Elderly. Volume 1: Long Term Care* 10 (1979); Moroney, *supra* note 4, at 109.

[10] Senate Report, *supra* note 5, at 3027.

[11] *Id.* Vladeck calls this process "Inventing the ICF." Vladeck, *supra* note 3, at 63.

was called intermediate care. The Senate Finance Committee expected that the new lower level of care would remove states' financial incentive to classify Medicaid recipients as needing skilled care and thus save money.

> This amendment could result in a reduction in the costs of title XIX, by enabling States to use lower cost facilities more appropriate to the needs of thousands of persons, thus avoiding the higher charges for skilled nursing homes when care of that kind is not needed.[12]

The summary of the Social Security amendments presented on the Senate floor makes plain the financial reason for creating the new lower level of care:

> *Federal Matching for Assistance Recipients in Intermediate Care Facilities*
>
> Under current law, vendor payments may be made with Federal sharing only in behalf of persons in medical facilities, such as skilled nursing homes. There is no Federal vendor-payments matching for people who need institutional care in the intermediate range between that which is provided in a boarding house (for which eligible persons may receive a money payment under the money payment programs), and those who need the comprehensive services of skilled nursing homes.
>
> The committee bill would provide for a vendor payment in behalf of persons who qualify for OAA, AB or APTD, and who are living in facilities which are more than boarding houses but which are less than skilled nursing homes. The rate of Federal sharing for payments for care in those institutions would be at the same rate as for medical assistance under title XIX. Such homes would have to meet

---

[12] Senate Report, *supra* note 5, at 3027.

> safety and sanitation standards comparable to those required for nursing homes in a given state.
>
> This provision should result in a reduction in the cost of title XIX by allowing States to relocate substantial numbers of welfare recipients who are now in skilled nursing homes in lower cost institutions.[13]

The new level of care was called "intermediate" apparently because, in the Committee's view, it would be care in the "intermediate range" between boarding homes and skilled nursing homes.

Congressional amendments in 1971 which made intermediate care available for medically needy Medicaid recipients[14] confirmed the cost-saving purpose of the ICF level of care. Senator Long, chairman of the Senate Finance Committee, supported the Harris-Bellmon amendment extending ICF benefits to medically needy recipients:

> In order to provide a less costly institutional alternative to skilled nursing home care, the Committee and the Congress approved in 1967 an amendment to title XI of the Social Security Act which authorized Federal matching for a new classification of care provided in "intermediate care facilities."[15]

---

[13] 113 Cong. Rec. 32599 (Nov. 15, 1967).

[14] Medically needy recipients are those whose income and/or resources are too high to qualify for cash assistance benefits but whose medical expenses are high enough that the State permits them to "spend-down" and establish Medicaid eligibility. 42 U.S.C. § 1396a(a)(10)(C), 42 C.F.R. §§ 435.800 et seq., *see Beltran v. Myers, supra* note 8. Coverage for these recipients is optional with States.

[15] 117 Cong. Rec. 44721 (Dec. 4, 1971). This language, placed in the Congressional Record by Senator Long, would have been

[footnote continued]

According to the Senate Finance Committee, the 1971 amendment was intended

> to clarify congressional intent with respect to intermediate care and to make such care, where appropriate, more generally available as an alternative to costlier skilled nursing home or hospital care.[16]

Just as the 1967 amendment creating intermediate care was intended to reduce reliance on skilled nursing care for categorically needy Medicaid recipients, the 1971 amendment extending ICF coverage to medically needy Medicaid recipients was intended to reduce their reliance on more costly SNF care.[17]

This legislative history makes plain that skilled nursing and intermediate care are concepts having significance only in the context of the Medicaid (and Medicare) statute. They are not pre-existing medical terms that Congress, in enacting the Medical Assistance Program, recognized and adopted.[18] Rather, they are concepts

---

Senate Finance Committee Report language if the amendment extending ICF care to medically needy recipients had been added by the Committee.

[16] *Id.*

[17] *Id.*

[18] Indeed a medically-derived system of levels of care is not possible and would not make sense in long-term care. While long-term care residents have medical needs, they also and predominantly have social needs. Residents are institutionalized as much because of the absence of social networks that can provide care informally and because of the existence of a payment system for institutional (but generally not for non-institutional) care as because of purely "medical" needs. Comptroller General, "Entering a Nursing Home—Costly Implications for Medicaid and the Elderly," PAD-80-12 (Nov. 26, 1979); Pollak, *supra* note 9,

[footnote continued]

created out of whole cloth by Congress to ensure primarily fiscal goals. Congress invented different statutory "levels of care" for fiscal reasons, then mandated that States enact strict utilization controls in order to ensure that "excessive" care at government expense is not provided.

B. Levels of Care in Practice

In practice, level of care principles have served three distinct administrative functions for the Medical Assistance Program:[19] classifying residents,[20] classifying facilities[20] and setting Medicaid reimbursement rates.[21]

Whatever their value in classifying facilities and setting rates, levels of care are arbitrary and essentially meaningless with respect to resident classifications.[22]

---

at 1-8 ("Lower medical and technical intensity, greater relative and absolute importance of social care elements, and different goals are the essential characteristics of long-term care that differentiate it from acute care." p. 8). Long-term care is fundamentally different from acute care and cannot have acute care's medical principles neatly superimposed.

[19] Bishop, C., et al., "Nursing Home Levels of Care: Problems and Alternatives," 2 *Health Care Financing Review* 33 (Fall, 1980).

[20] Facilities participating in the Medical Assistance Program are classified, and accordingly certified, as able to provide skilled or intermediate care, or both, depending on the facility's preference. The classification determines which Conditions of Participation a facility must satisfy for Medicaid certification.

[21] Reimbursement decisions follow facility level of care certification. Although Medicaid reimbursement for long-term care facilities has undergone repeated statutory change since 1965, a general guiding principle has always been that intermediate care is cheaper than skilled care.

[22] *See* Vladeck, *supra* note 3, at Chapter 6, "The Game of Levels."

That levels of care fail to identify the actual needs of long-term care residents in any coherent fashion is made plain by national statistics on States' utilization of the two levels of care. According to data prepared by the Department of Health, Education and Welfare (now Health and Human Services), in 1973, 1.8% of Medicaid recipients in long-term care facilities in Louisiana were in SNFs and 98.2% in ICFs. In the same year the reverse occurred in Florida: 89.3% of Medicaid recipients in long-term care facilities were in SNFs and only 10.7% were in ICFs.[23] No difference in the actual needs of long-term residents can account for such wide disparity among States in utilization rates of the two levels of care.

II.

UTILIZATION CONTROL ACTIVITIES, CONDUCTED BY FACILITIES AND PHYSICIANS, ENFORCE LEVEL OF CARE PRINCIPLES.

Level of care principles are enforced through statutorily-mandated utilization control mechanisms. A primary purpose of utilization control activities is ensuring that Medicaid recipients are placed in the proper level of care.

The Medicaid statute requires participating States to develop procedures to safeguard against the unnecessary

---

[23] Community Research Applications, Inc., *Excerpt Summary of a National Study of Levels of Care in Intermediate Care Facilities (ICFs).* Prepared for Health Services Administration under Contract Number HSA-105-74-176, April, 1976. (Issued by Bureau of Quality Assurance, Health Services Administration, Public Health Service, U.S. Department of Health, Education and Welfare.) As reprinted in Vladeck, *supra* note 3, at 138. *See also* Pollak, *supra* note 9, at 11.

utilization of all Medicaid-covered services, 42 U.S.C. § 1396a(a)(30). For noninstitutional services, federal regulations permit States to perform utilization control activities on a sample basis. 42 C.F.R. § 456.22.

In order to give effect to the statutory levels of care which it created, however, Congress enacted a significantly more comprehensive program of utilization control for institutional services. Utilization control activities for institutional long-term care encompass not only utilization review, 42 U.S.C. § 1396a(a)(30), but also medical review in SNFs, 42 U.S.C. § 1396a(a)(26)(A), independent professional review (IPR) in ICFs, 42 U.S.C. § 1396a(a)(31)(A), inspection of care and services for SNFs and ICFs, 42 U.S.C. § 1396(a)(26)(B), (C), and 42 U.S.C. § 1396a(a)(31)(B), (C), respectively, and a variety of facility and physician obligations. Facilities are specifically required to conduct and participate in utilization control activities as a condition of participation in the Medical Assistance Program. 42 U.S.C. § 1396a(a)(28), incorporating 42 U.S.C. § 1395x(j) for SNFs (especially 42 U.S.C. § 1396x(j)(8), (12)), 42 U.S.C. § 1396d(c) for ICFs.

As respondents demonstrate in their brief, these statutorily-mandated utilization control activities place obligations on facilities and physicians to take an active role as partners with the State in controlling utilization of long-term care services. Independent of the utilization review process, facilities and physicians have additional statutory obligations to ensure that Medicaid recipients are placed in the proper level of care. The responsibilities of the State, on the one hand, and facilities and physicians, on the other, to conduct utilization control activities are mutually reinforcing and flow in both directions. An attending physician must make

an initial determination that a Medicaid recipient needs a particular level of care, 42 C.F.R. § 456.270 for SNFs, 42 C.F.R. § 456.370 for ICFs, and that decision must be reviewed by the State agency for each Medicaid recipient. 42 C.F.R. § 456.271 for SNFs, 42 C.F.R. § 456.371 for ICFs. Similarly, all reports of inspection of care teams must be sent to facilities and to their utilization review committees, as well as to the State agencies, 42 C.F.R. § 456.612.

States, however, have the final responsibility to ensure that utilization control mechanisms are effective. Failure to establish an effective utilization control program subjects States to loss of federal matching funds. 42 U.S.C. § 1396b(g), 42 C.F.R. §§ 456.650 *et seq.* Significantly, the federally-mandated sanction applies to utilization control activities conducted by facilities and physicians. States which cannot show, for example, that physicians are certifying and recertifying the need for inpatient care may have their federal share reduced. 42 U.S.C. § 1396b(g)(1)(A), 42 C.F.R. § 456.652(a)(1). Similarly, physicians' failure to establish and review each Medicaid recipient's plan of care subjects States to loss of federal funds. 42 C.F.R. § 456.652(a)(2).

Utilization control, made necessary by level of care requirements, is carried out jointly by the State, facilities and physicians in mutually dependent functions for which the State has final and complete responsibility.

III.

LEVEL OF CARE AND UTILIZATION CONTROL REQUIREMENTS ARE NOT APPLIED TO PRIVATE-PAY RESIDENTS.

While level of care and utilization control are central to the Medical Assistance Program, they play no role whatsoever when residents pay directly for their own care.[24] Private-pay residents may buy whatever care they want at whatever level they choose. Federal Medicaid law places no restrictions on the private choices of private-pay residents.

Physicians do not make level of care determinations about their private-pay patients. While they may prescribe medications and courses of treatment and engage in other traditional functions of medical practice for their patients who reside in nursing homes, they have no need to make non-medical determinations of level of care.

Utilization control is also absent from the life of a private-pay nursing home resident. Utilization control activities begin either when a Medicaid recipient is admitted to a facility or when a private-pay resident exhausts personal financial resources and applies for Medical Assistance. 42 C.F.R. § 456.333(a), (b) for SNFs, 42 C.F.R. § 456.433(a), (b) for ICFs. So long as a resident remains private-pay, he is free to occupy whatever nursing home bed he likes.

New York State's argument that a finding of no state action in this case leaves Medicaid residents in the same position as private-pay residents (Petitioners' Brief, p. 37) is disingenuous. It is plain that but for the require-

---

[24] Comptroller General, *supra* note 18, at 103.

ments of the Medical Assistance Program, no level of care decisions and transfers would ever be made.

IV.

STATE ACTION IS PROPERLY FOUND WHENEVER LEVEL OF CARE DECISIONS ARE MADE BY UTILIZATION REVIEW COMMITTEES, FACILITIES OR PHYSICIANS.

Level of care decisions, whether made by utilization review committees, long-term care facilities, or physicians, constitute state action within the meaning of this Court's decisions.

As demonstrated above, the Medical Assistance statute invented the concepts of skilled nursing and intermediate levels of care for institutional long-term care and then required States to enforce those concepts through a comprehensive utilization control program. But for the Medical Assistance statute, level of care determinations and the utilization control activities which enforce them would not occur in long-term care.

Level of care decisions are totally unlike the enforcement of creditors' liens in *Flagg Brothers, Inc. v. Brooks*, 436 U.S. 149 (1978), and the termination of utilities in *Jackson v. Metropolitan Edison Co.*, 419 U.S. 345 (1974). While the Court observed that Flagg Brothers would enforce its liens "even in the absence of . . . authorization" of any state statute, 436 U.S. at 163 n.12, no similar claim can be made that facilities and physicians would make level of care determinations in the absence of Medicaid requirements. They do not make these decisions for private-pay residents.

The initiative to conduct level of care determinations does not come from any traditional practice of long-term health care, as did procedures for terminating utilities in

Jackson, 419 U.S. at 357. Indeed, not only has the State "put its own weight on the side of the proposed practice [of requiring level of care determinations] by ordering it," *Jackson*, 419 U.S. at 357, but it has also specifically mandated that level of care determinations be made in the first instance. The fact that the impetus for the challenged activity comes directly and exclusively from law, and not from the private parties' own historical practices, directly and conclusively distinguishes this case from *Flagg Brothers*, *Jackson* and *Moose Lodge v. Irvis*, 407 U.S. 163 (1972).

When facilities and physicians are engaging in their traditional practices, state action may or may not be present. This case need not decide whether all aspects of institutional long-term care are covered by state action doctrine. When facilities and physicians are performing the function of making level of care determinations that are mandated by the Medical Assistance law and would not be made but for that law's explicit requirements, however, state action is properly found. *Polk County v. Dodson*, 50 U.S.L.W. 4077, 4080 (Dec. 14, 1981). *Accord*, *Estelle v. Gamble*, 429 U.S. 97 (1976); *O'Connor v. Donaldson*, 422 U.S. 563 (1975).

CONCLUSION

For all of the reasons outlined above, *amicus* urges affirmance of the decision of the Second Circuit Court of Appeals.

Respectfully submitted,

By _____

TOBY S. EDELMAN
PATRICIA NEMORE

NATIONAL SENIOR
CITIZENS LAW CENTER
1424 16th Street, N.W.
Suite 300
Washington, D.C. 20036
(202) 232-6570

Attorneys for Amicus Curiae,
National Citizens' Coalition
for Nursing Home Reform

January 20, 1982